Paoli Pharmacy
Consent and Release - Arexvy

Patient Name: _____Date of Birth:_____

Address: _____City: _____State:_____

Phone number: _____Primary Care Physician: _____

I acknowledge that I understand the benefits and risks of the requested vaccination as described in the Vaccine Information Sheet, a copy of which is attached to this Consent and Release. I confirm that Paoli Pharmacy, Inc, has answered to my satisfaction all of my questions about the vaccine and the vaccination procedure. I request and consent that the vaccination be given, as I direct Paoli Pharmacy, either to me or to the person named above. I understand that I am giving Paoli Pharmacy permission to release any medical or other information necessary to my physician, Medicare, Medicare HMO, or insurance company as applicable, to enable Paoli Pharmacy to process my insurance claims with respect to the vaccination. I authorize my vaccination documentation to be forwarded to the physician named above, any applicable collaborative prescribing physician, and the online state Immunization Information System.

I, for myself, my heirs, executors and assigns hereby release Paoli Pharmacy and their officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine as provided by the manufacturer and any negligence of Paoli Pharmacy in connection with the related injection of the vaccination. I understand that the laws of my state may affect my remedies in connection with this vaccination.

After receiving your vaccine, it is recommended that you remain in the pharmacy for 15 minutes. Serious reactions are rare and usually occur within 15 minutes of injection. Please refer to the vaccine Information Sheet provided.

_____

Signature of Person to Receive Vaccine Date

Please answer the following questions by checking the boxes:

(If the question is unclear, please ask the pharmacist to explain)

Questions	Yes	No	Don't know
Are you sick today?			
Have you had a severe allergic reaction to a previous dose of Arexvy?			
Have you ever had Guillain Barre syndrome within 6 weeks of a previous vaccination?			
Are you receiving any kind of temporary immunosuppressive therapy? (Ex: prednisone, hydrocortisone, chemotherapy or radiation)			

To be filled out by vaccinator:

Date Administered: _____/_____/_____

Dose: 0.5ml Lot #:_____ Exp. Date:_____

Manufacturer: GSK Site of Injection: Left Deltoid / Right Deltoid

Route of Administration: ____IM_____

Date VIS provided: _____ VIS version: 07/24/2023

Pharmacist Name:_____ Signature:_____