COVID-19 Vaccine Consent for Patients 18 yrs and Older

I have received a copy of and have read the 2023-2024 Vaccine Fact Sheet/Information Sheet for the Monovalent COVID-19 vaccine that I am receiving (the "Vaccine") and understand the risks and benefits. Furthermore, I have also had an opportunity to ask questions about the Vaccine. I believe the benefits outweigh the risks and I agree to receive the Vaccine. I voluntarily assume full responsibility for any reactions that may result from my child's receipt of the Vaccine. I understand that I should wait in the vaccination area as instructed following my receipt of the Vaccine to be monitored for any adverse reactions. Information regarding receipt of the Vaccine may be shared with my physician or other healthcare provider, for public health reporting purposes, and as otherwise required or permitted by law. In consideration for receiving the vaccine at this event, I, for myself and on behalf of my child and our respective heirs, executors, personal representatives and assigns, hereby release Pediatric Associates of Western CT and its affiliates, subsidiaries, and their respective directors, contractors, agents, employees, and volunteers (collectively, "Pediatric Associates of Western CT"), along with any other organizations, individuals, or volunteers affiliated with Pediatric Associates of Western CT where I am receiving the Vaccine (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt of this or these Vaccine(s). The Released Parties shall not at any time or to any extent whatsoever, be liable, responsible, or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the Vaccine(s).

Patient name _____ DOB_____

Signature _____ Today's date _____