To: All Healthcare Providers for:
Patient Named_____
with Date of Birth_____

And all Representatives, Subsidiaries, Parent Companies, Attorneys, Department Chairs, Chief Quality Officer, Chief of Staff, Chief Medical Director/Officer, Medical Executive Committee, Board of Trustees/Directors

c/o Chief Executive Officer for Hospital/Facility

RE: Caregivers and Consent document

Attached is my Caregivers and Consent document.

Please ensure that this Caregivers and Consent document is clearly accessible in the electronic medical record at all times for all my healthcare providers. Furthermore, the date this Caregivers and Consent document is received by the hospital/facility serves as the date I reaffirm my carefully planned and intentional wishes as described within this Caregivers and Consent document.

Thank you in advance for your attention to this matter.

Signature: _____ Date: _____

Print Name: _____
Address: _____
Phone: _____
Email: _____

NOTARIZED ACKNOWLEDGEMENT

State of:_____
County of:_____

The signer of this document PERSONALLY came and appeared before me and was acknowledged by me, the undersigned Notary, with the name _____ who is a resident of _____County, State of _____.

My commission expires_____

_____
Notary Public

Caregivers and Consent

I, _____, advise all physicians, nurses, and other caregivers, that this Caregivers and Consent document reflect my current wishes for my care and are carefully planned and intentional wishes. This Caregivers and Consent document also reflects my deeply held religious and spiritual beliefs; please ensure that this Caregivers and Consent document is clearly accessible in the electronic medical records at all times for all of my care providers.

Receipt of this Caregivers and Consent document by the hospital/facility serves as notice that I will report to the Medical Board any physician who violates my carefully planned and intentional wishes that are based upon my deeply held religious and spiritual beliefs and are delineated within this Caregivers and Consent document. Furthermore, the date this Caregivers and Consent document is received by the hospital/facility serves as the date I reaffirm my carefully planned and intentional wishes as described within this Caregivers and Consent document.

MY CAREFULLY PLANNED AND INTENTIONAL WISHES THAT ARE BASED UPON MY DEEPLY HELD RELIGIOUS AND SPIRITUAL BELIEFS INCLUDE:

_____**I DO NOT CONSENT TO THE USE OF MEDICATIONS WITHOUT MY BEING INFORMED OF EACH MEDICATION'S RISKS, BENEFITS, AND ALTERNATIVES BEFORE THEY ARE ORDERED.** Only **AFTER** that information is communicated shall I choose to either grant consent or to not grant consent for each medication that is ordered. The only **EXCEPTIONS** to this include lifesaving medications required to resuscitate me and medications used as part of a surgery/anesthesia plan.

_____**I DO NOT CONSENT** to receiving **ANY** vaccine or booster for COVID19 or COVID19 variant.

_____**I DO NOT CONSENT** to receiving the seasonal Flu vaccine.

_____**I DO NOT CONSENT** to receiving the Pneumococcal vaccine.

_____**I DO NOT CONSENT** to receiving **ANY** vaccination for **ANY** purpose or disease.

_____**I DO NOT CONSENT** to the use of Remdesivir, or its brand name called Veklury, or **ANY** drug related to Remdesivir or Veklury under **ANY** circumstances.

_____**I DO NOT CONSENT** to the use of Favipiravir, or its brand name called Avigan, or **ANY** drug related to Favipiravir or Avigan under **ANY** circumstances.

_____**I DO NOT CONSENT** to a ventilator in the case of a COVID19 diagnosis, or COVID19 variant diagnosis, or any virus diagnosis (such as, but not limited to, Bird Flu virus diagnosis, Nipah virus diagnosis, Hantavirus diagnosis) **WITHOUT** consultation with myself regarding the risks, benefits, and alternatives **PRIOR** to the implementation of the ventilator. Only **AFTER** that information is communicated to me shall I choose to either grant consent or to not grant consent for the ventilator.

____**I DO NOT CONSENT** to medications related to COVID19 protocol, or COVID19 variant protocol, or any virus protocol (such as, but not limited to, Bird Flu virus protocol, Chikungunya virus protocol, Nipah virus protocol, Marburg virus protocol, Ebola virus protocol, Hantavirus protocol) **WITHOUT** consultation with myself regarding the risks, benefits, and alternatives **PRIOR** to the implementation of the medication. Only **AFTER** that information is communicated to me shall I choose to either grant consent or to not grant consent for each medication.

_____**I DO NOT CONSENT** to receiving any processed food, such as high-fructose corn syrup or seed oils. The only acceptable oil for me is butter, ghee, beef tallow, or coconut oil. Acceptable forms of protein are eggs, lamb, bison, beef, or non-farmed seafood; but they must not be prepared with seed oils. If the hospital/facility is unable to provide this food for me, my family or friends will bring it for me.

_____**I DO NOT CONSENT** to receiving Acetaminophen or Tylenol.

_____**I DO NOT CONSENT** to receiving any blood transfusions that contain blood products derived from COVID19 vaccinated donors or COVID19 variant vaccinated donors.

_____**I DO NOT CONSENT** to receiving any blood transfusions that contain blood products derived from COVID19 vaccinated donors or COVID19 variant vaccinated donors **EXCEPT** in the case of a bona fide emergency for which blood is needed to save my life.

____**I ALSO DO NOT CONSENT TO THE FOLLOWING**:

_____

_____

_____ **I REQUEST AND CONSENT** to autologous and directed blood donations via the hospital blood bank, if provided, or BlessedByHisBlood.com, or SafeBlood.com.

_____**I REQUEST AND CONSENT** to the use of 1mg of Budesonide via nebulizer every 4 to 6 hours for COVID19 diagnosis, or COVID19 variant diagnosis, or any virus diagnosis with respiratory issues.

____**I REQUEST AND CONSENT** to the implementation of alternative treatments for COVID19 and COVID19 variants. Alternative treatments may include, but are not limited to, Ivermectin and Hydroxychloroquine. If the facility does not allow for the use of any alternative treatments, **I REQUEST AND CONSENT** that I be consulted for discharge to another facility.

____**I REQUEST AND CONSENT** to the implementation of alternative treatments for a virus diagnosis (such as, but not limited to, Bird Flu virus diagnosis, Chikungunya virus diagnosis**,** Nipah virus diagnosis, Marburg virus diagnosis, Ebola virus diagnosis, Hantavirus diagnosis). Alternative treatments may include, but are not limited to, Ivermectin, Hydroxychloroquine, and Nitazoxanide. If the facility does not allow for the use of any alternative treatments, **I REQUEST AND CONSENT** that I be consulted for discharge to another facility.

____I ALSO REQUEST AND CONSENT TO THE FOLLOWING:

_____

_____

All the items in this Caregivers and Consent document shall remain in effect unless I choose to revoke in writing; no one else may alter or amend this Caregivers and Consent document.

_____ _____ _____

Signature Initials Date

NOTARIZED ACKNOWLEDGEMENT

State of:_____

County of:_____

The signer of this document PERSONALLY came and appeared before me and was

acknowledged by me, the undersigned Notary, with the name _____

who is a resident of _____County, State of _____.

My commission expires_____

_____

Notary Public