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	y primary care provider I understand t	that failure to check authoriz	e/do not authorize v	will serve as authorizatio	n.) (South Dake	ota, Maine, Massachus	etts, and Ne	ew Ham	pshire o
tand I have the right to object to the sharing of my data to	o the above-mentioned parties throu	gh such registries.). For minc	r's parent or guardi	ian, below consent confir	ms receipt of w	ritten notice to visit a p	ediatrician	annually	y.
x									
Signature of Patient or Parent/Guardian			Prin	nted Name			Dat	<u>e</u>	
Below for Pharmacy Use Only:	WA ONLY: Substitution		- / n	Dispense a			/=		
Vaccine Name Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)		UA Pu	b. Da
DVID-19()				#	IM	R / L Deltoi			
Flu ()			0.5		IM	R / L Deltoi	-	1010	
Shingrix®		GSK	0.5	<u> </u>	IM	R / L Deltoi		/4/20	122
Prevnar 20®		Pfizer	0.5	1	IM	R / L Deltoi	<u> </u>		
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rdering RPh Signature:ame of Administrator:		PCN:				R / L D# :			