**RENEW DAY SPA**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent for weight loss treatment with

Semaglutide/Cyanocobalamin subcutaneous injections. I am in good health with no known

contraindications to take this medication. I will follow all recommendations and advisements for weight

loss treatment with Semaglutide/Cyanocobalamin. I am aware of and understand all possible adverse

reactions related to Semaglutide/Cyanocobalamin. I have received educational teaching/demonstration

and understand all administration instructions of a subcutaneous injection and correct safe-keeping

and/or disposal process of used medication vials, syringes, and needles. I am aware that ReNew Day

Spa, Ronda Mullenax, NP, and Jerry Simmons, MD are not responsible for any adverse reactions and/or

medication dose errors/misuse done by me.

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Date

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Patient/Client Printed Witness Printed

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Patient/Client Signature Patient/Client Signature