VACCINATION SAFETY VOUCHER

Name of Individual To Be Vaccinated_____
Male__ Female__Age___Birth Date_____Height____Weight____

I (name of physician or person
injecting)_____
(check one) MD__DO___ND___RN___NP__PA__MA__Pharm.D___
do by assure the above named individual or parent/guardian that the vaccine(s) and/or any mRNA gene therapy shot, named specifically as.....

_____

_____

is 100% safe and effective and will not cause injury, disease or death to the above named person. I will take full responsibility for any damage done to the patient and will be responsible for any adverse effects from the vaccines or mRNA gene therapy shot I injected them with.

Date_____

Provider Name_____

Provider License #:_____

Provider Signature_____
(stamp not acceptable/original signature only)
Provider Address_____
Provider Phone_____