ID Verified	
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Patient may	leave at:		

ADDRESS  CITY  COUNTY  STATE  LIPCODE  RACE/ETHNICITY:  COUNTY  STATE  LIPCODE  RACE/ETHNICITY:  INSURANCE COMPANY  RACE/ETHNICITY:  INSURANCE COMPANY  POLICY/MEMBER ID  NO INSURANCE  RACE/ETHNICITY:  INSURANCE COMPANY  POLICY/MEMBER ID  NO INSURANCE  RACE/ETHNICITY:  TYPE OF WORK  INSURANCE COMPANY  POLICY/MEMBER ID  NO INSURANCE  ARE YOU EVER HAD A COVID-19 VACCINE?  YES NO  RACE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR  HAVE YOU EVER HAD AN ALLERGIC PREACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR  HAVE YOU EVER HAD AN ALLERGIC PREACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR  HAVE YOU EVER TESTED POSITIVE FOR COYUP-19?  HAVE YOU EVER TESTED POSITIVE FOR COYUP-19?  HAVE YOU RECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19: YES NO  ON YOU HAVE A WEAKENED IMMUNE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER.  YES NO  ON YOU PREGNANT OR REASTREEDING?  YES NO  By signing below, you acknowledge the following:  TO PRODUCE AND ALLERGIC PREACHES TO YOU CANNOT RECEIVE YOUR INLEGTION IN YOUR LEFT ARM?  YES NO  By signing below, you acknowledge the following:  TO PRODUCE AND ALLERGIC PREACHES TO YOUR AND TREATMENT OF COVID-19: Aller having found it to be safe and effective in accordance with Emergency Use Authorization Fellowing to the Covid Preaches To You Cannot RECEIVE YOUR INLEGTION IN YOUR LEFT ARM?  YES NO  By signing below, you acknowledge the following:  TO PRODUCE AND ALLERGIC PREACHES TO YOUR AND TREATMENT OF COVID-19: Aller having found it to be safe and effective in accordance with Emergency Use Authorization (EUA)  BY SIGNING BELOW AND THE ARM TO YOUR AND TREATMENT OF COVID-19: Aller AND TREATMENT	LOVELACE FAMILY MEDICINE COVID-19 VACCINE CONSENT FORM FOR DATE OF VACCINATION							
SOCIAL SECURITY # STATE ZIPCODE  FHONE  GENDER  RACERTHNICITY:  TYPE OF WORK  INSURANCE COMPANY  POLICY/MEMBER ID  NO INSURANCE  NO BRAND  DATE RECEIVED  NO INSURANCE  ARE YOU EVER HAD A COVID-19 VACCINE? YES NO  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU EVER EVER DAY WACKINES IN THE PAST 14 DAYS? YES NO  HAVE YOU EVER EVER DAY WACKINES IN THE PAST 14 DAYS? YES NO  HAVE YOU RECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19: YES NO  DOYOU HAVE A WEAKENEED IMMINE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER,  VES NO  ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM? YES NO  ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM? YES NO  By signing below, you acknowledge the following:  The FOOd and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-COV-2 (Cornavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may be reperience and adverse, even unexpected, reaction to it, including, without limitation, a ferregency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may be represed to adverse treatment in case of adverse reactions. You insurance company ill held in the administration of the signs and symptoms listed on the Vaccine to the signs and symptoms listed on the Vaccine Information 5 heet. You are making an informed decision to receive the vaccine, you finish, and are seen add any addi	LAST NAME	CONSENT FU					AGE	
COUNTY STATE ZIPCODE  PHONE  RACERTHNICITY: TYPE OF WORK  INSURANCE COMPANY  POLICYMEMBER ID NO INSURANCE  NO INSURANCE COMPANY  POLICYMEMBER ID NO INSURANCE  NO INSURANCE COMPANY  POLICYMEMBER ID NO INSURANCE  ARE YOU EVER HAD A COVID-19 VACCINE? YES NO BRAND DATE RECEIVED  ARE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU EVER DAYN VACCINES IN THE PAST 14 DAYS? YES NO  HAVE YOU EVER TESTED POSITIVE FOR COVID-19? YES NO IF YES, WHEN?  HAVE YOU RECEIVED MINONCLIONAL, ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19; YES NO  DO YOU HAVE A WEAKENED BIMINE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER, YES NO  OR USE OF IMMUNOSUPPRESSIVE THERAPIES?  ARE YOU PRECINANT OR BREAST EEDING? YES NO  ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM? YES NO  By signing below, you acknowledge the following:  The FOOd and Druy Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-GOV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use AuthORIZANCE REQUIRED AND ADMINISTRATION OF A COVID-19, after having found it to be safe and effective in accordance with Emergency Use AuthORIZANCE REPROPERS AND ADMINISTRATION OF A COVID-19, after having found it to be safe and effective in accordance with Emergency Use AuthORIZANCE REPROPERS AND ADMINISTRATION OF A COVID-19, after having found it to be safe and effective in accordance with Emergency Use AuthORIZANCE (EUL)  FOR STAFE OWN OF A COVID-19, after having found it to be safe and effective in accordance with Emergency Use AuthORIZANCE (EUL)  FOR STAFE OWN OF A COVID-19, after having found it to be safe and effective in accordance with Emergency Use AuthORIZANCE (EUL)  FOR STAFE OWN OF THE OWN OF THE OWN O				(220/12)		5,112 01 2		7.02
FHONE  GENDER  RACE/ETHNICITY:  TYPE OF WORK  INSURANCE COMPANY  POLICY/MEMBER ID  NO INSURANCE  NO BRAND  DATE RECEIVED  ARE YOU EVER HAD A COVID-19 VACCINE?  YES NO  HAVE YOU EVER HAD AN ALLERGIC BEACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR  THAT CAUSED YOU TO GO TO THE HOSPITAL?  AND YOU RECEIVED ANY VACCINES IN THE PAST 14 DAYS?  YES NO  HAVE YOU EVER TESTED POSITIVE FOR COVID-19?  YES NO IF YES, WHEN?  HAVE YOU EVER TESTED POSITIVE FOR COVID-19?  YES NO IF YES, WHEN?  HAVE YOU PRECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19: YES NO  DO YOU HAVE A WEAKENED IMMUNE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER.  YES NO  RUSS OF IMMUNOSUPPRESSIVE THERAPIES?  ARE YOU PREGNATO REREASTREEDING?  YES NO  By signing below, you acknowledge the following:  The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-Co-V2 (Coronavirus of COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the tom of the Emergency Use Authorization requirements. Information of the vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms itself on the administration of the vaccine being administered to you in a reaction and available and assigns, and its of	SOCIAL SECURITY #		ADDRESS			<u> </u>		
GENDER  RACE/ETHNICITY:  TYPE OF WORK    POLICY/MEMBER ID	CITY		COUNTY		STATE		ZIPCODE	
INSURANCE COMPANY  POLICY/MEMBER ID  NO INSURANCE  HAVE YOU EVER HAD A COVID-19 VACCINE? YES NO  RARE YOU FEELING SICK TODAY?  YES NO  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR YES NO  HAVE YOU RECEIVED ANY VACCINES IN THE PAST 14 DAYS?  YES NO  HAVE YOU DECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19: YES NO  OR USE OF IMMUNOSUPPRESSIVE THERAPIES?  ARE TOU PRECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19: YES NO  OR USE OF IMMUNOSUPPRESSIVE THERAPIES?  ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM?  YES NO  By signing below, you acknowledge the following:  The Food and Drug Administration has approved the vaccine being administered to you in the form of the Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/NS form. The vaccine being administered to keep you from getting COH-19-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and ischarge Lovelace with the administration of the vaccine. You insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. The vaccine is administered to you for insurance compa	PHONE		l	EMAIL				
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THAT CAUSED YOU TO GO TO THE HOSPITAL?  HAVE YOU RECEIVED ANY VACCINES IN THE PAST 14 DAYS?  YES NO  IF YES, WHEN?  HAVE YOU EVER TESTED POSITIVE FOR COVID-19?  YES NO  IF YES, WHEN?  HAVE YOU EVER TESTED POSITIVE FOR COVID-19?  YES NO  IF YES, WHEN?  HAVE YOU RECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19; YES NO  DO YOU HAVE A WEAKENED IMMUNE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER, YES NO  ARE YOU PREGNANT OR BREASTFEEDING?  ARE YOU PREGNANT OR BREASTFEEDING?  YES NO  ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM?  YES NO  By signing below, you acknowledge the following:  The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-COV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization requirements. Vortice with the vaccine has been made available to you in the form of the Emergency Use Authorization requirements. Vortice and administered to you is not quaranteed to keep you from getting COVID-19, You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine high administered decision to receive the vaccine. You form leading Lovelace  Family Medicine, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccinae is administered over 2 doses, and in order to be effective, you will need to receive both doses. Should you experience any symptoms, such as, without limitation, a fer or monitoring and to receive treatment in case of adver	ARE YOU FEELING SICK	TODAY?	YES	NO				
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HAVE YOU RECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19?YES NO DO YOU HAVE A WEAKENED IMMUNE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER, OR USE OF IMMUNOSUPPRESSIVE THERAPIES? ARE YOU PREGNANT OR BREASTFEEDING? YES NO ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM? YES NO By signing below, you acknowledge the following: The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-COV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Lovelace Family Medicine, its affiliates and assigns, and its officers, and employees from any linless, injury liness, injury liness, injury discharge Lovelace Family Medicine, its affiliates and assigns, and its officers, and employees from any linless, injury lines, and the vaccine and any additional services provided in the event of an adverse reaction. The vaccine is administered over 2 doses, and in order to be effective, you will need to receive both doses. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.  I acknowledge that I have had an opportunity to read, understand and ask ques	HAVE YOU RECEIVED AN	NY VACCINES IN THE PAST	14 DAYS?	YES	NO			
DO YOU HAVE A WEAKENED IMMUNE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER, OR USE OF IMMUNOSUPPRESSIVET HERAPIES?  ARE YOU PREGNANT OR BREASTFEEDING?  YES NO  ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM?  YES NO  By signing below, you acknowledge the following: The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-COV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Lovelace Family Medicine, its affiliates and assigns, and its officers, and employees from any illness, including, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15-30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. The vaccine is administered over 2 doses, and in order to be effective, you will need to receive both doses. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.  I acknowledge that I have had an opportunity to read, u	HAVE YOU EVER TESTE	D POSITIVE FOR COVID-19?	YES	NO	IF YES, W	/HEN?		
OR USE OF IMMUNOSUPPRESSIVE THERAPIES?  ARE YOU PREGNANT OR BREASTFEEDING?  YES  NO  ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM?  YES  NO  By signing below, you acknowledge the following: The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-CoV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Lovelace Family Medicine, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15-30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. The vaccine is administered over 2 doses, and in order to be effective, you will need to receive both doses. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.  I acknowledge that I have had an opportunity to read, understand and ask questions about the vaccine and the COVID-19 Vaccine Emergenc	HAVE YOU RECEIVED M	ONOCLONAL ANTIBODIES (	OR CONVALES	SCENT PLASI	MA FOR TREATMEN	T OF COVID-19	?YES	NO
ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM?  YES NO  By signing below, you acknowledge the following: The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-COV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Lovelace Family Medicine, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15-30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. The vaccine is administered over 2 doses, and in order to be effective, you will need to receive both doses. Should you experience any symptoms, such as, without limitation, a fever of more than 101-15. F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.  I acknowledge that I have had an opportunity to read, understand and ask questions about the vaccine and the COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheets/VIS relating to the vaccine I will be receivin			ISED BY SOM	ETHING SUCI	H AS HIV, CANCER,	YES	S NO	
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Pfizer BioNTech Covid-19 Vaccine Lot # Exp  Dose #: (circle) 1st dose / 2nd dose Date of Service:  Site: (circle) Left Deltoid / Right Deltoid Administered by:  Monitor for 15 min / 30 min Scanned by: Documented by:	SARS-CoV-2 (Coronavi requirements. Informati Fact Sheet/VIS form. To experience an adverse, Vaccine Information She Family Medicine, its affil the administration of the treatment in case of adv services provided in the need to receive both dochills, headache, myalgi please go to your neare I acknowledge that I ha Emergency Use Authori	rus or COVID-19), after hat on about the vaccine has been unexpected, reaction eet. You are making an infliates and assigns, and its evaccine. You also agreeverse reactions. Your insuration of an adverse reactions strength of an adverse reaction of an experient is, or pain at the injection strength of the management of the injection of the management of the injection of the inj	ving found it been made a ered to you is in to it, including formed decisiofficers, and to wait in the rance compation. The vacace any symposite, please covider if it can ead, understativis relating to the property of the control o	to be safe ar vailable to you and guarante one, without lin ion to receive employees for vaccination my will be bill cine is admirtoms, such a contact your habe done safe and and ask to the vaccine	ad effective in according to the form of the eed to keep you from itation, all or some the vaccine. You form any illness, injudiced for the administ distered over 2 doses, without limitation ealthcare provider ely or contact 9-1-1 questions about the eld will be receiving	rdance with Energency Learn getting COVer of the signs a fully release a cury, loss, or dautes for monitoration of the values, and in order as soon as positive vaccine and tand I accept a	nergency Use Use Authorizat /ID-19. You nand symptoms and discharge mage that ma oring and to reaccine and anyer to be effectivore than 101.5 ssible. If it is a like the COVID-19 all risks associated.	Authorization ion (EUA) nay s listed on the Lovelace y result from ceive y additional ve, you will s F, fatigue, an emergency, Vaccine ated with
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