

CONSENT FOR VACCINATION

Consent-E
Consent for Vaccination



IDN13150509

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

- I have read the Vaccine Information Statement(s) for the vaccine(s) checked below.
- I have read and fully understand the applicable Vaccine Information Statement(s) and if I have questions I have had the opportunity to have them answered by the physician/health care provider.
- I have not had a previous reaction to any vaccine.
- I hereby authorize the physician/health care provider to perform the vaccination(s) upon myself/the patient.

- Hepatitis B (Hep B)
- Diphtheria/Tetanus/Acellular Pertussis (DTaP)
- Haemophilus Influenzae b (Hib)
- Inactivated Poliovirus (IPV)
- Pneumococcal Conjugate (PCV)
- Rotavirus (ROTA)
- Measles/Mumps/Rubella (MMR)
- Varicella
- Hepatitis A (Hep A)
- Diphtheria/Tetanus (DT, pediatric)
- Tetanus/Diphtheria/Acellular Pertussis (Tdap)
- Tetanus/Diphtheria (Td, adult)

- Pneumococcal Polysaccharide (PPV)
- Inactivated Influenza
- Meningococcal Polysaccharide (MPV)
- Meningococcal Conjugate (MCV)
- Rabies
- Tetanus Toxoid
- Palizumab (Synagis™)
- Human Papillomavirus (HPV Vac)
- Live Intranasal Influenza
- Zoster
- Other: _____

Date: _____

Time: _____ A.M. / P.M.

IF CONSENTING PARTY IS OTHER THAN PATIENT:

Signature of Consenting Party

Print Name

Relationship