Child & Family Agency of Southeastern Connecticut, Inc.

VACCINATION CONSENT FORM (NON-COVID/FLU)

"*" indicates required fields

Client's Name*

_____________________________ ____
First Last

Date of Birth
_______/ ______/ _____ (mm/dd/yyyy)

Primary Care Provider* ______________________________

Client is*

- ○ Self
- ○ Child

Check all vaccinations that apply to be given*

- ☐ Dtap: diphtheria, tetanus, pertussis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hib: Haemophilus Influenza type b
- ☐ HPV-9: human papilloma virus
- ☐ IPV: polio
- ☐ MCV: meningococcal
- ☐ Meningococcal serotype B
- ☐ MMR: measles, mumps, rubella
- ☐ MMRV: measles, mumps, rubella, varicella
- ☐ PCV: Pneumococcal Conjugate
- ☐ Tdap: tetanus, diphtheria, pertussis
- ☐ Td: tetanus
- ☐ Varicella

Client (check one) *

- ○ has Private Insurance
- ○ has HUSKY/Medicaid
- ○ has No insurance
- ○ is Native American or Alaskan Native

Child & Family Agency of Southeastern Connecticut, Inc.

Vaccine Information Statement

Consent for Service*

☐ I have read or have had explained to me the information included in the Vaccination Information Statement(s) for the vaccinations selected above. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccinations and ask that the vaccine dose and/or series be given to me or the person named above for whom I am authorized to make this request. I also give permission for this vaccination to be reported to the primary care provider listed above.

For Child & Family Agency Medical Clinic Visits: I give permission for my insurance to be billed at time of visit. I understand that a sliding scale will be available for those without insurance. I authorize the release of any medical information necessary to process my claim. I also authorize payment of health benefits to Child & Family Agency for services provided. I understand and acknowledge that I have read and understand this consent.

Signature*

____

Relationship to Patient (if <18 years of age) _____________________

Date* ___________________________________