

Client First, Last Name: _____

Client Date of Birth: _____

VACCINATION CONSENT FORM

Client First Name _____

Client Last Name _____

Date of Birth (MM/DD/YYYY) ____/____/____

Primary Care Provider _____

Client is (*check one*):

- ☐ Self
- ☐ Child
- ☐ Other _____

Client (*check one or more*):

- ☐ Has Private Insurance
- ☐ Has Husky/Medicaid
- ☐ Has no insurance
- ☐ Is Native American or Alaskan Native

Parent/Guardian's name (if client <18 years of age)

Parent/Legal Guardian First Name _____

Parent/Legal Guardian Last Name _____

Parent/Legal Guardian Phone _____

School Client Attends _____

Grade/Teacher _____

Check all vaccinations to be given:

- ☐ Dtap: diphtheria, tetanus, pertussis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hib: Haemophilus Influenza type b
- ☐ HPV-9: human papilloma virus
- ☐ IPV: polio
- ☐ Meningococcal ACWY
- ☐ Meningococcal B

- ☐ MMR: measles, mumps, rubella
- ☐ MMRV: measles, mumps, rubella, varicella
- ☐ PCV: Pneumococcal Conjugate
- ☐ Tdap: tetanus, diphtheria, pertussis
- ☐ Varicella

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.

Parent/Legal Guardian Signature (if client <18 years of age)

Date (MM/DD/YYYY)

Printed Name (First & Last)

Signature

Client Signature

Date (MM/DD/YYYY)

Printed Name (First & Last)

Signature
