Immunization Consent Form

Patient Name: **Date of Birth:**

X	DTaP/DT	X	HPV	X	PCV
X	Tdap	X	IPV	X	Rotavirus
X	Hib	X	Meningococcal	X	Flu
X	Hep A	X	MMR/MMRV		
X	Hep B	X	Varicella		

A copy of the appropriate Center for Disease Control and Prevention Vaccine Information Statements has been provided. I have read, or have been explained, the information about the diseases and the vaccines listed below. I have or will have the opportunity to ask questions. I believe that I understand the benefits and risks of the vaccines cited, and ask that the vaccines listed above be given to the person named.

I also give authorization to the following people to bring my child for immunizations:

1.
2.
3.

Patient Name: ______________________________

Parent Signature: ______________________________ **Date:** ______________

Parent Name: ______________________________