
Patient ID number

Patient Name

INFORMED CONSENT FOR VACCINES

I have read or had read to me information about the vaccines listed below. I have been given the Vaccine Information Statement(s) for the vaccines. I had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) to be administered and ask that the vaccine(s) checked be given to me or the patient. I also give permission to share my immunization record with facilities or institutions, which are required by law to have such records and with my other health care provider(s).

Vaccine	VIS Sheet	VIS Date	Vaccine	VIS Sheet	VIS Date	Vaccine	VIS Sheet	VIS Date
<input type="checkbox"/> IPV	EPID-234	_____	<input type="checkbox"/> Varicella	EPID-245	_____	<input type="checkbox"/> Tdap	EPID-252	_____
<input type="checkbox"/> MMR	EPID-237	_____	<input type="checkbox"/> DT <input type="checkbox"/> DTaP	EPID-246	_____	<input type="checkbox"/> Rotavirus	EPID-253	_____
<input type="checkbox"/> Influenza	EPID-239A	_____	<input type="checkbox"/> Hepatitis A	EPID-247	_____	<input type="checkbox"/> HPV	EPID-254	_____
<input type="checkbox"/> Influenza (LIVE)	EPID-239B	_____	<input type="checkbox"/> PCV7	EPID-248	_____	<input type="checkbox"/> Shingles	EPID-255	_____
<input type="checkbox"/> Hib	EPID-242	_____	<input type="checkbox"/> PPV23	EPID-248A	_____	<input type="checkbox"/> Other (specify)	_____	_____
<input type="checkbox"/> Hepatitis B	EPID-243	_____	<input type="checkbox"/> Meningococcal	EPID-249	_____			
<input type="checkbox"/> Td	EPID-244	_____	<input type="checkbox"/> Yellow Fever	EPID-251	_____			

Signature of Patient or Other Authorized Person

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