Department of Allergy & Immunology

Immunization Informed Consent

I have received a vaccine fact sheet and had the opportunity to read the information and ask questions regarding the vaccine(s). I understand I may elect not to have the vaccine(s) given to me/my child, and if so, the chance of acquiring the disease(s) indicated is significantly increased.

I understand that most vaccine(s) involve an injection into the arm, buttocks, or leg. The oral polio vaccine is given by mouth.

MEDICATION	DOSE, ROUTE, SITE OF ADMINISTRATION	DATE GIVEN	MANUFACTURER	LOT #	NAME, TITLE OF PERSON GIVING DRUG	DATE NEXT DOSE DUE
DPT (Diphtheria, Pertussis, Tetanus)						
DT						
Td						
Hemophilus Influenza type b (Hib)						
Pneumococcal						
Influenza						
Polio OPV						
Polio IPV						
Hepatitis A						
Varicella						
Measles						
Mumps						
Rubella						
MMR						
Hepatitis B						
Tuberculin Skin Test						
Other						

PRINT OR TYPE NAME OF PATIENT

Witness

Signature of Patient, Parent/Legal Guardian

Date

ORIGINAL REMAINS WITH MEDICAL RECORD