Consent for Immunization Administration Form

Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

Email:

Parent/Guardian Information (if applicable)

Name:

Relationship to Patient:

Phone Number:

Immunization Information

Vaccine Name:

Dose (if applicable):

Date of Administration:

Health Screening

- [ ] Are you currently ill?
- [ ] Do you have any allergies to vaccines or medications?
- [ ] Have you had any reaction to previous vaccinations?
- [ ] Are you currently taking any medications?
- [ ] Are you pregnant or breastfeeding?

Consent

- [ ] I have read or have had explained to me information about the vaccine, and fully understand the benefits and risks. I give my consent for the immunization administration.

Signature:

_____

Date: