Immunization Consent Form

Patient's Full Name

Date of Birth

Parent/Guardian Name (if under 18)

Address

Phone Number

Vaccine Information

Name of Vaccine

Date of Immunization

Healthcare Provider

Medical Information

Allergies

Current Medications

Past Adverse Reactions to Vaccines

Consent

I acknowledge that the nature and purpose of the immunization has been explained to me.
Signature of Patient/Guardian

Date

Signature of Healthcare Provider

Date