Mobile Vaccination Clinic Consent Form

Full Name

Date of Birth

Phone Number

Email Address

Residential Address

Have you had a severe allergic reaction (e.g., anaphylaxis) to a vaccine or injectable medication?

Do you have any allergies?

Are you currently feeling sick?

Are you pregnant or breastfeeding?

Vaccine to be Administered

Dose Number

Medical Conditions (if any)

Consent Statement

I have read or have had explained to me the information about the vaccine. I have had a chance to ask questions and they were answered to my satisfaction. I understand the risks and benefits of receiving this vaccination.

☐ I consent to receive the vaccine.

Date

Signature