# Immunocompromised Patient Vaccine Consent Form

## Patient Information

Full Name:

Date of Birth:

Medical Record Number:

Contact Number:

Address:

## Medical Information

Primary Diagnosis / Reason for Immunocompromised Status:

Current Medications:

Allergies (including vaccine-related allergies):

Physician/Provider Name:

## Vaccine to be Administered

Vaccine Name:

Dose Number:

Date of Administration:

## Consent

☐ I have read and understand the information provided to me regarding the vaccine.

☐ I have had the opportunity to ask questions and they have been answered to my satisfaction.

☐ I voluntarily consent to receive the indicated vaccine.

Patient/Legal Representative Name:

Signature:

Date:

## Provider Verification

Provider Name:

Signature:

Date: