Maternal Immunization Consent Form

Patient Information

Name:

Date of Birth:

Address:

Phone Number:

Emergency Contact Name & Phone:

Pregnancy Information

Gestational Age (weeks):

Expected Delivery Date:

Healthcare Provider Name:

Vaccine Information

Vaccine Name:

Date of Vaccination:

Manufacturer/Lot Number:

Screening Questions

☐ History of severe allergic reaction

☐

Currently has a fever or illness

☐ Other (specify below)

Details (if any):

Consent

I have read or have had explained to me the information regarding maternal immunization. I have had a chance to ask questions, and these were answered to my satisfaction. I consent to receive the vaccine.

Signature:

_____

Date:

Person obtaining consent (Print Name):

Date: