MRN: _____

Date: _____

## Consent for Administration of Immunizations

Staff Member Name: _____ Witness Name: _____

Biological Parent/Legal Guardian Name: _____

_____ with date of birth _____ is due for vaccinations.
Patient Name

_____ has recommended immunization with the following vaccines selected below
Provider Name
based on the current Center for Disease Control and Prevention's (CDC) Vaccine Recommendation Schedule.

| Vaccine/Disease | |
|---|---|
| Diphtheria-tetanus-pertussis (DTaP) | Pneumococcal conjugate (PCV13, PCV15, PCV20) |
| *Haemophilus influenza* type b (Hib) | Pneumococcal polysaccharide (PPSV23) |
| Hepatitis A (Hep A) | Polio, inactivated |
| Hepatitis B (Hep B) | Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series) |
| Human papillomavirus (HPV) | Tetanus-diphtheria-acellular pertussis (Tdap) |
| Influenza (IIV4, LAIV4) | Tetanus-diphtheria (Td) |
| Measles-mumps-rubella (MMR) | Varicella (Chickenpox) |
| Meningococcal | Other (specify) |
| Meningococcal B (MenB-4C, MenB-FHbp) | |

My provider has discussed the risks and benefits of these vaccines as well as the possible side effect(s) of each. A Vaccine Information Statement (VIS) has been made available to me, on the Holston Medical Group website and/or in the office exam room, for each vaccine, with detailed information. I have reviewed the VIS and been given the opportunity to ask questions related to the selected vaccine(s). All questions have been answered to my satisfaction.

**I understand this consent form will cover all vaccines received during this office visit.**

My signature below indicates that I am the biological parent or legal guardian of the child listed above and consent to him/her/them receiving the specified vaccines.

_____ _____
Parent/Legal Guardian Date

_____ _____
Provider Signature Date