**Immunization** **Informed Consent Record**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Date:** |  | **Record #:** |  |

**Attestation**

I certify that I have received relevant Vaccine Information Statements (VIS) or Emergency Use Authorization (EUA) Fact Sheets that provide current CDC/FDA information about the vaccine(s) I have elected to receive. I further certify that the benefits and potential side effects of such immunization(s) have been thoroughly explained to me and I do understand such information.

**I have accepted the vaccine(s) checked (√) below:**

|  |  |  |
| --- | --- | --- |
| **√** | **Vaccine (√ = Received)** | **Vaccine Information Statements or Emergency Use Authorization Fact Sheet Provided** |
| **Yes** | **No** | **Date Provided** | **Edition Date of VIS or EUA** |
|  | **Diphtheria** |  |  |  |  |
|  | ***Haemophilus Influenza* type b (Hib)** |  |  |  |  |
|  | **Hepatitis B** |  |  |  |  |
|  | **Measles** |  |  |  |  |
|  | **Mumps** |  |  |  |  |
|  | **Pertussis** |  |  |  |  |
|  | **Pneumococcal Conjugate** |  |  |  |  |
|  | **Pneumococcal Polysaccharide (PPV)** |  |  |  |  |
|  | **Respiratory Syncytial Virus (RSV)** |  |  |  |  |
|  | **Rubella** |  |  |  |  |
|  | **Tetanus** |  |  |  |  |
|  | **Trivalent/Quadrivalent Influenza (IIV)** |  |  |  |  |
|  | **Influenza (Live, Intranasal)** |  |  |  |  |
|  | **Varicella (Chickenpox)** |  |  |  |  |
|  | **COVID-19 (SARS-CoV-2) dose #1**  |  |  |  |  |
|  | **COVID-19 (SARS-CoV-2) dose #2 (if applicable)** |  |  |  |  |

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| **Administrative Information** |
| **Date vaccination(s) administered:** |  |
| **Name of vaccine(s) manufacturer:** |  |  |  |
| **Lot number of vaccine(s) used:** |  |  |  |
| **Expiration date of vaccine(s) used:** |  |  |  |
| **Name of person administering vaccine:** |  | **Title:** |  |
| **Address of person administering vaccine:** |  |

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| **Authorized Signatures** |
| **Person Receiving Immunization (OR)****Legal Representative:** |  | **Date:** |  |
| **Person Administering Immunization(s):** |  | **Date:** |  |

**Filing Instructions:**

Place the original signed and dated copy of this form in the individual’s permanent medical record. If requested, provide photocopy of this record to individual or his/her legal representative.