GRANDVIEW
FAMILY MEDICINE
My Health, My Family, My Clinic

VACCINE CONSENT FORM

I understand the benefits and risks of each vaccine listed below and I understand that I will be given a "Vaccine Information Sheet" for every vaccine at each appointment. I have had the chance to ask questions regarding the following vaccines and they were answered to my satisfaction. I hereby give my consent for each of the vaccines checked below to be given to the patient listed.

Patient's Name _____ Date of Birth _____ /_____ /_____

- ☐ Hepatitis B
- ☐ Diphtheria/Tetanus/Pertussis (DTaP)
- ☐ Haemophilus Influenza b (HIB)
- ☐ Inactivated Polio (IPV)
- ☐ Pneumococcal (Prevnar)
- ☐ Rotavirus
- ☐ Measles/Mumps/Rubella (MMR)
- ☐ Varicella
- ☐ Hepatitis A
- ☐ Inactivated Influenza
- ☐ Live Intranasal Influenza
- ☐ Tetanus/Diphtheria/Pertussis (Tdap) (adolescent)
- ☐ Meningococcal (adolescent)
- ☐ Human Papillomavirus (HPV) (ages 9-26)
- ☐ Other:_____
- ☐ Other:_____

This authorization will remain in effect until the patient noted above is eighteen years of age, or until a cancellation request is received in writing. A new authorization must be filled out to make any changes.

_____ _____
Signature of Parent/Legal Guardian Printed Name

_____ _____ /_____ /_____
Relationship to Patient Date

_____ _____
Signature of Witness Printed Name