Vaccine Administration Record for Children

Name:_________________________________ Birthdate:______________ Age:_______

Phone: (home)_____________________________ (cell)_____________________________

Address:____

Mother's Name:____________________________ Father's Name:_______________________

Insurance Status (circle one): None Private CareSource Unison United Health Care Medicaid

If private insurance are immunizations paid: Yes_______ No_______

Race: (select one or more) ___AS –Asian Pacific ___BL Black or African American ___CA Caucasian ___CH Chinese ___FI Filipino ___HA Hawaiian ___ IN Native American/Alaskan Native ___JA Japanese ___NW Other Non-White ___ UN Unknown

Ethnicity : Hispanic or Latino ____Yes ____No

Gender : _____Male ______Female

Child's Physician Name & Phone: ____

Allergies: ____

I have been provided with a copy of the Vaccine Information Statement(s) (VIS) circled below. I have read, had explained to me, and understand the information in the VIS(s). I request that any of the vaccine(s) circled below which are <u>still required</u>, be given to the child named above for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Ohio Immunization Registry (IMPACT) on behalf of the child named above.

DT DTaP Tdap Td Polio/IPV MMR HepB Varicella Meningococcal

Influenza Hib HPV HepA PCV13 PPV23 Rotavirus Other_________

- I have had a chance to ask questions which were answered to my satisfaction.
- I understand the benefits and risks of the vaccine(s).
- I understand that certain immunizations are mandatory for attendance at school.
- I understand that this consent covers <u>the administrations of all required single dose and multiple dose vaccines.</u>
- I understand that multiple dose vaccines will be administered in accordance with the required time between each immunization.
- I ask that the vaccine(s) indicated on this record be given to the person named above for whom I am authorized to make this request on this date and/or scheduled subsequent dates.
- I further understand that the health status of the child receiving the vaccine will be assessed at the time of each administration and if a change has occurred, immunization(s) may be deferred.
- This consent will remain in effect for one year from the date of the authorized signature.
- I understand that consent may be withdrawn at any time.

Signature: ____ Date:______________
(Parent, Guardian or designee)

(REVERSE SIDE FOR OFFICE USE ONLY)