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Patient Information

Informed Consent for Vaccine Administration

Patient Name: _____ DOB: _____

I have been given the Vaccine Information Statement(s) for vaccines listed below. I have read or had read to me information regarding each vaccine to be given. I have had the opportunity to ask questions which have been answered to my satisfaction. I believe and understand the benefits and risks of the selected vaccine(s) that are to be administered to me or to the patient. I also give consent to share this immunization with other facilities, institutions, and my other health care provider(s), which are required by law to have such records.

Vaccine Given

() Beyfortus
() DT/DTap
() Flu (__ Shot __ Mist)
() Gardasil
() Hepatitis A
() Hepatitis B
() MMR
() MMRV
() Menquadfi
() Pentacel
() Prevnar
() Rotavirus
() Tdap
() Varicella
() Other _____

Signature of Patient or Other Authorized Person

Date

[] -- I wish to withdraw my child from the Kentucky Immunization Registry (KYIR)

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