



OWENSBORO Pediatrics

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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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