Owensboro Pediatrics
2200 East Parrish Avenue, Bldg B, Suite 101
Owensboro, KY 42303
(270) 683-3232 fax (270) 852-1600

INFORMED CONSENT FOR VACCINE ADMINISTRATION

Patient Name________________________________DOB_______

I have been given the Vaccine Information Statement(s) for the vaccines selected 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 record with other facilities, institutions, and my other health care provider(s), which are required by law to have such records.

Vaccine	VIS Date
☐ DT /DtaP	07-30-01
☐ IPV	01-01-00
☐ Hib	12-16-98
☐ HBV	07-11-01
☐ Prevnar	09-30-02
☐ Rotavirus	04-12-06
☐ MMR	01-15-03
☐ Varicella	01-10-07
☐ Hep A	03-21-06
☐ Tdap	07-12-06
☐ Menactra	11-16-06
☐ Gardasil	09-05-06

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Signature of Patient or Other Authorized Person Date