Vaccine Consent

Date: _____

*** PLEASE FILL OUT **ALL** SECTIONS OF THIS FORM

I hereby consent to receive the following vaccines (Please check vaccine(s) to be administered):

□ TDaP - (Tetanus, Diphtheria, Pertussis) – Adacel
□ FLU - Influenza vaccine
□ *MMR - Measles, Mumps, Rubella (must check **both** boxes)
□ *I consent that I am not pregnant or trying to conceive. I also consent that I have not received an MMR vaccine within the past 28 days.
□ OTHER – _____

_____ _____
Print Name Date of Birth

_____
Phone number

_____
Address

_____ _____
Insurance Provider Policy #

□ I understand that my insurance may not cover the vaccine(s), in which case, I will be responsible for the cost.

**** PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD**

_____

SIGNATURE