

## PEDIATRIC PERMISSION TO VACCINATE

I have read or had explained to me the information about the following checked vaccines. I received the vaccine information statement (VIS) for this vaccine. I have had a chance to ask questions and they have been answered to my satisfaction. I understand the benefits and risks of the vaccines checked below and ask that they be given to me or to the person named below for whom I am authorized to make this request.

VACCINE TO BE GIVEN	VIS PUBLICATION DATE	LANGUAGE (If other than English)
<input type="checkbox"/> Haemophilus influenzae type B (Hib)		
<input type="checkbox"/> Hepatitis A		
<input type="checkbox"/> Hepatitis B		
<input type="checkbox"/> Human papillomavirus (Gardasil)		
<input type="checkbox"/> Influenza – IIV (inactivated – intramuscular)		
<input type="checkbox"/> Influenza – LAIV (live attenuated – intranasal – age 2 years and over)		
<input type="checkbox"/> Measles, mumps, rubella (MMR)		
<input type="checkbox"/> Meningococcal conjugate – MCV4		
<input type="checkbox"/> Pneumococcal conjugate – PCV13 (Prevnar 13)		
<input type="checkbox"/> Pneumococcal polysaccharide – PPSV (Pneumovax – age 2 years and over)		
<input type="checkbox"/> Poliovirus, inactivated (IPV)		
<input type="checkbox"/> Rotavirus		
<input type="checkbox"/> Diphtheria, Tetanus, acellular Pertussis (DTaP – up through 6 years of age)		
<input type="checkbox"/> Tetanus, diphtheria (Td)		
<input type="checkbox"/> Tetanus, Diphtheria, acellular Pertussis (Tdap)		
<input type="checkbox"/> Varicella (Chickenpox)		
<input type="checkbox"/> Rabies		

Name of person to receive vaccine (print): \_\_\_\_\_ Age/DOB \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 (If a minor, signature of person authorized to give consent)

Signature/title of Witness: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Name of Interpreter (if used): \_\_\_\_\_

PATIENT LABEL



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