

## VACCINE INFORMATION AND CONSENT FORM

<b>Patient Name</b> _____		
First	Middle	Last
<b>Address</b> _____		
Street	City	State      Zip
<b>Telephone</b> _____		
Home	Other	
<b>Date of Birth</b> ___ / ___ / ___ mo    day    yr	<b>Sex</b> Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>Social Security #</b> -    -    -
<b>Race/Ethnicity: Check one</b> Asian <input type="checkbox"/> Black (Non-Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Multiracial <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> American Indian, Alaskan Native <input type="checkbox"/> Unknown <input type="checkbox"/>		
<b>Insurance: Check all that apply</b> Amerigroup <input type="checkbox"/> Tri-Care Prime <input type="checkbox"/> Wellcare <input type="checkbox"/> Tri-Care Standard <input type="checkbox"/> Medicaid <input type="checkbox"/> UNHC (SHBP) <input type="checkbox"/> Medicare <input type="checkbox"/> Cigna (SHBP) <input type="checkbox"/> Medicare Part D <input type="checkbox"/> None <input type="checkbox"/>		<b>Insurance Number:</b> _____ _____ Please provide a copy of your card.

<i><b>OFFICE USE ONLY</b></i>		<b>Record of Immunization</b>				<i><b>OFFICE USE ONLY</b></i>	
Vaccine	Manufacturer	Lot #	Exp. date	Dose	Route	Site	Nurse

I understand the information in the Vaccine Information Pamphlet(s) and/or the Important Information Statement(s) for the vaccine(s) indicated. All of my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccines requested and ask that they be given to me or to the person named for whom I am authorized to make this request.

\_\_\_\_\_

Date of Immunization
Patient/Guardian Signature