CHRISTIANA CARE

CNSNT

PEDIATRIC IMMUNIZATION CONSENT

Instruction:
To completed by the clinician/clinical support staff and signed by the parent/guardian prior to immunization.

Patient name:

Patient date of birth:

I, ______________________ (parent/guardian), request and give consent for ______________________ (child) to receive the following vaccines ordered by ______________________ (provider):

- ☐ Diphtheria, tetanus, and acellular pertussis vaccine (DTaP)
- ☐ *Haemophilus influenzae* type B vaccine (Hib)
- ☐ Inactivated poliovirus vaccine (IPV)
- ☐ DTaP, inactivated poliovirus and *Haemophilus influenzae* type B vaccine (Pentacel®)
- ☐ DTaP, hepatitis B and inactivated poliovirus vaccine (Pediatrix®)
- ☐ DTaP and inactivated poliovirus vaccine (Kinrix®)
- ☐ Tetanus, diphtheria, and acellular pertussis vaccine (Tdap)
- ☐ Hepatitis A vaccine
- ☐ Hepatitis B vaccine
- ☐ Human papillomavirus vaccine (HPV)
- ☐ Influenza (FLU)
- ☐ Meningitis Meningococcal conjugate
- ☐ Meningococcal serogroup B vaccine (Meningitis B)
- ☐ Measles-Mumps-Rubella (MMR) vaccine
- ☐ Varicella (Chickenpox) vaccine
- ☐ Pneumococcal 13-valent conjugate vaccine (Prevnar 13®)
- ☐ Pneumococcal 23-valent polysaccharide vaccine (Pneumovax®)
- ☐ MMR and Varicella (Chickenpox) vaccines (ProQuad®)
- ☐ Rotavirus

I have read a copy of the CDC Vaccine Information Statements (VIS) published on ______/______/______ (Publication Date) for each vaccine and have had the opportunity to ask any questions which were answered to my satisfaction. If I prefer to take home copies, I can ask for a copy of the VIS to take with me.

By signing below, I give consent for the above vaccine(s) to be administered.

______________________	______________________	___/___/___	__________
Parent/Guardian Signature	Relationship to Patient	Date	Time
______________________	______________________	___/___/___	__________
Staff Signature	Print Name	Date	Time

Interpretation: The information has been presented to the: ☐ patient ☐ representative ☐ decision maker in: ______________ (Language)

The person who provided the interpretation is a qualified medical interpreter.

______________________	______________________
Interpreter Name	Agency and ID# (if applicable)

______________________	______________________	___/___/___	__________
Witness Signature	Print Name	Date	Time