POST EXPOSURE VACCINE ADMINISTRATION
VISIT RECORD and CONSENT STATEMENT

I have read or have had explained to me the information on this form about **POST EXPOSURE** rabies treatment and received a copy. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of rabies vaccine and agree to assume such risks. I ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

Information about person to receive vaccine (Please Print)				
Name: Last	First	Middle Initial	Birth date	Age
Address: House number, Street	City	County	State & Zip	
Signature of person to receive vaccine or person authorized to make the request: X _____ Date: _____				

For Clinic/Office Use						
Body weight:	lbs kg	Vaccine DAY 0	Vaccine DAY 3	Vaccine DAY 7	Vaccine DAY 14	Vaccine DAY 28 **Immunocompromised Only**
Vaccine Given (Circle one)	Human Rabies Immune Globulin	RabAvert HDCV RVA	RabAvert HDCV RVA	RabAvert HDCV RVA	RabAvert HDCV RVA	RabAvert HDCV RVA
Date Administered						
Vaccine Manufacturer						
Vaccine Lot Number						
Site & Route of Injection						
Signature & Title						

Health Care Provider Name _____

Health Care Provider Address _____