UNIVERSITY HEALTH CENTER

VACCINE CONSENT FORM

Gardasil (HPV) _____
Hepatitis A _____
Hepatitis B _____
Twinrix (Hep A & B) _____
Immune Globulin _____
Influenza:
Injectable _____
FluMist _____
Japanese Encephalitis _____
Meningococcal:
Menomune (SC) _____
Menactra (IM) _____
MMR _____
Pneumovax _____

Polio _____
Rabies _____
Tetanus/Diptheria _____
Tdap
(Tetanus, Diptheria, Pertussis) _____
Typhoid:
oral _____
typhim V_1 _____
Varicella (Chicken Pox) _____
Yellow Fever _____

Other: _____
_____
_____

I have read the information about the disease(s) and the vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or to the person named below for whom I am authorized to make this request. I understand there is a fee of $_____ for the vaccine(s) and by my signature below I agree to pay the listed amount. Visitors are required to pay this fee in cash or by credit card (MC or Visa). Students can elect to have this fee billed to their student account.

Information about person to receive vaccine (Please print)				
Name: Last First Middle Initial			Birthdate	Age
University ID #:	Telephone			
Address: Street	City	County	State	Zip

Signature of person to receive vaccine or person authorized to make the request (Parent or guardian):

X _____ Date: _____

For Office Use Only

Date Vaccine Administered: _____
Vaccine Manufacturer: _____ Vaccine Lot Number: _____
Site of Injection: RA or LA L deltoid R deltoid
Signature and Title of Vaccine Administrator: _____ RN or LPN

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