Texas Children's Hospital®

Name:
DOB:
MRN:

VACCINE INFORMATION STATEMENT AND CONSENT

Nurse/MA Administering Immunization:	**DOS:**

☐ Multiple Vaccines (DTaP / IPV / Hep B / Hib / PCV)	☐ Tdap
☐ DTaP	☐ Td
☐ IPV	☐ MenACWY
☐ Hep B	☐ MenB
☐ Hib	☐ HPV9
☐ Rotavirus	☐ Influenza Inactivated (IIV)
☐ PCV	☐ Influenza Live Attenuated (LAIV)
☐ MMR	☐ Typhoid
☐ Varicella	☐ Yellow Fever
☐ MMRV	☐ Japanese Encephalitis
☐ Hep A	☐ Rabies
☐ RSV	☐ Tick-borne Encephalitis
☐ PPSV23	☐ Other

I have been given a copy of the Vaccine Information Sheet (VIS) for each vaccine I or my child are to receive, issued by the Centers for Disease Control (CDC). I have read, or have had explained to me, information about the diseases and the vaccines listed above. I have had the opportunity to ask questions and receive answers about the vaccines listed above. I understand the risks and benefits of the vaccines cited and ask that the vaccine(s) listed above be given to the person named above for whom I am authorized to consent to this request.

Printed Name of Parent(s) if known/ Patient

_____

Printed Name of Managing Conservator/Guardian (if applicable): _____

Signature of Patient/Person Giving Consent: _____Date: _____Time:_____

I am the (circle one) Patient Parent Managing Conservator Guardian

Documentation of Call to Parent or Legal Guardian
(For patients accompanied by adult other than parent or legal guardian)

Call to Parent by: _____ on Date/Time: _____

Parent name: _____ Phone No. called: _____

Did Parent authorize adult representative to give consent? (please check below)

□ Yes □ Did not answer □ No

Revised: 07/2024