WELD COUNTY DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

VACCINE CONSENT RECORD

I, _____ (*print name of the parent or guardian who signs below*), hereby request and give my consent that the following vaccine(s) be administered to the person named below ("*the vaccinee*"), for whom I am authorized to make this request and consent.

REQUIRED- place check mark after each vaccine you are consenting be administered:

□ **All recommended vaccines**

□ **DTaP (Diphtheria, Tetanus, pertussis for children under 7 years old)** □ **Hepatitis A** □ **Hepatitis B**

□ **HIB (haemophilus influenzae type B)** □ **HPV (human papillomavirus)** □ **IPV (Polio)** □ **Influenza** □ **MMR**

□ **Meningococcal** □ **Pneumonia** □ **Rotavirus** □ **Td** □ **Tdap (Tetanus, Diphtheria, Pertussis)** □ **Varicella (Chickenpox)**

□ **Other (*Please list each vaccine)* _____**

I was given and have read the Centers for Disease Control (CDC) Vaccine Information Statement (VIS) for each vaccination indicated above. I was also given the Weld County Department of Public Health Vaccination Questionnaire, which I have completed with regard to the vaccine, and have returned with this Vaccine Consent Record. I understand the benefits and risks of the vaccine and request that the vaccine indicated be given to the person named below for whom I am authorized to make this request. I have had the opportunity to review or receive the notice of privacy policy (HIPAA). I understand this record will be kept on file at the Weld County Health Department.

I have had a chance to ask questions about the CDC VIS for each vaccination to be administered to the vaccinee, and those questions were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and give my consent that the vaccine(s) checked above be given to the vaccinee. I hereby release the Weld County Department of Public Health and Environment and its employees from any liability for any results which may occur from the administration of the vaccine(s) to the vaccinee.

* _____ * _____

Signature of parent or guardian **Date**

* _____

Printed name of parent or guardian signing above. (*Please print clearly.)*

Information about the vaccinee (the person receiving the vaccine[s]).

(*Please print clearly).*

Last Name	**First Name**	**Middle Initial**	**Birth Date**	**Age**

Street	**City**	**State**	**Zip Code**	**Phone**

*This consent is good for **ONE** clinic visit only*

Please ask for another consent form if the child will be coming in for another visit without a parent