VACCINATION CONSENT

You have requested or your medical provider has recommended one of the following vaccines. Please carefully review the Vaccine Information Statement (VIS) explaining the vaccine's benefits, risks and contraindications. If you have any questions, please ask the provider BEFORE receiving the vaccine.

PATIENT INFORMATION

- ☐ Flu Vaccine
- ☐ Hepatitis A Vaccine
- ☐ Hepatitis B Vaccine
- ☐ HIB
- ☐ MMR
- ☐ Other:
- ☐ Pneumococcal
- ☐ Polio
- ☐ Shingles (Zostavax)
- ☐ Tetanus diphtheria /(Td)
- ☐ Varicella Zoster Chicken Pox
- ☐ Medicare
- ☐ HPV
- ☐ Self-Pay

- I have read the VIS regarding the vaccine I am about to receive.
- I am aware that like any medicine, there are contraindications and risks involved.
- I have been given the opportunity to ask questions about the vaccine.
- I deny any complaint of illness or fever at this time.
- I hereby release Xpress Urgent Care, its subsidiaries and agents of the corporations, practitioners and employees from any and all liability which may result from any risk factors or contraindications associated with receiving this vaccine.
- If you experience any significant reaction, call us, return here or contact your physician immediately.

☐ I voluntarily consent to receive the vaccine noted above.

Patient Name:________________________________ DOB:____________________________

Signature:

FOR CLINIC USE

The patient was given the appropriate VIS and the opportunity to ask questions regarding the vaccine prior to administration.

Date: ______________________________________ Site L/R:_________________________

Administered by:______________________________ Initials:__________________________

EXP:_______________________________________ Lot#:____________________________