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# Infant and Child Vaccine Consent - HIB

Printed Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Date: \_\_\_\_\_ MA Initials: \_\_\_\_\_

### ***Vaccine Information:***

**Today you are receiving the following vaccination:** \_\_\_\_\_

Lot Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Vaccines may be a **single dose** or require **multiple doses** over the course of months or years. Please make sure that you understand the requirements of the particular vaccine you or your child are receiving today before you leave the office.

The Pediatric HIB vaccine is given in 4 (4) doses over the course of 12 to 15 months. Your schedule should adhere to the following interval:

- Dose at 2 months of age
- Dose at 4 months of age
- Dose at 6 months of age
- Dose at 12-15 months of age

First dose: \_\_\_\_\_ Second dose: \_\_\_\_\_  
2 months old                      4 months old

Third dose: \_\_\_\_\_ Fourth dose: \_\_\_\_\_  
6 months old                      12-15 months old

I have read the patient information sheet and would like to receive this vaccination. If the costs of the vaccine, and/or with any administration fees, are not covered by my Health Insurance Company, I and/or my parent/guardian agree to pay for the full price of the vaccine and its administration at the time of the first dose. I understand that if the intended recipient of the HPV vaccination is outside of the ages 9-26 years old, it is unlikely that any insurance will cover the cost of either fee.

\_\_\_\_\_  
Patient/Parent/Guardian/Responsible Party

\_\_\_\_\_  
Date