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Vaccine Consent/ Responsibility/ Authorization

Printed Patient Name: _____

Patient DOB: _____Date: _____MA Initials: _____

Vaccine Information:

1) Today you are receiving the vaccination: _____**Manufacturer:** _____

1) Lot Number: _____ Vaccine Expiration Date: _____

2) Today you are receiving the vaccination: _____Manufacturer: _____

2) Lot Number: _____ Vaccine Expiration Date: _____

3) Today you are receiving the vaccination: _____Manufacturer: _____

3) Lot Number: _____ Vaccine Expiration Date: _____

The vaccine may be a **single dose** or require **multiple doses** over the course of the next 3 to 6 months. Please make sure that you understand the requirements of the particular vaccine you are receiving today before you leave the office.
The Adult **Hepatitis B** and **Cervarix** vaccines are given in three (3) doses over the course of six months. Your schedule should adhere to the following interval.

First dose: _____Second dose: _____Third dose: _____

Today **1 month** **6 months**

The **Gardasil** vaccine is given in three (3) doses over the course of six months. Your schedule should adhere to the following interval.

First dose: _____Second dose: _____Third dose: _____

Today **2 months** **6 months**

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