Immunization Consent Form

Sunshine Children's Clinic

Name (as it appears on insurance card): _____

Date of Birth: _____ Age: _____ Gender: Male / Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Payment Method: Self pay / Insurance

Eligibility: VFC _____ CHIPS _____ Private Insurance _____ Self Pay _____

Screening Questions (if you answer yes, please explain below)

1.	Are you sick today?	Yes	No
2.	Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No
3.	Have you ever had a serious reaction after receiving a vaccine?	Yes	No
4.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (diabetes), anemia or other blood disorder?	Yes	No
5.	Do you have cancer, leukemia, AIDS, or any other immune system problem?	Yes	No
6.	Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
7.	Have you had a seizure or other nervous system problem?	Yes	No
8.	During the past year, have you received a blood transfusion or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No
9.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No
10.	Have you received any vaccinations in the past 4 weeks?	Yes	No

Consent and waiver: I consent to the staff to administer the medication(s) mentioned below. I have reviewed the vaccine information sheet(s) and understand the benefits and risks of receiving this medication and choose to assume this risk. I fully release and discharge Sunshine Children's Clinic, its Providers and staff from any illness, injury, loss, or damage that may result there from. I acknowledge that I have received a copy of the clinic's privacy policies according to HIPAA. I assign payment of authorized insurance benefits due to me to be paid to the clinic and will pay any copay or deductible that result. I consent the release of medical information when necessary for billing, reimbursement, and medical protocol. I also allow for the clinic to report any medications received to the appropriate state vaccine registry. I agree to wait near the vaccination area for approximately 20 minutes to receive treatment in case of adverse reaction.

Signature of Patient/Guardian X: _____ Date: _____

Pediarix Prevnar HIB Rotateq DTAP Hep A MMR Varivax Kinrix Proquad Pentacel HBV TDaP Menveo Bexsero Gardasil Flu Covid Synagis

Administered by: _____ Title: _____ Date Given: _____

Vaccine	Lot Number	Expiration