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PERMISSION FOR IMMUNIZATION

For Children ages 2 months through 6 years

_____ **Child's Name** (Last, First, Middle) _____ **Date of Birth** (mm/dd/yyyy) _____ **Age**

Check all vaccines your child needs at this time:

- _____ DTaP - Diphtheria, Tetanus, and Acellular Pertussis Vaccine (under age 7 years)
- _____ Hib - Haemophilus Influenzae Type B Vaccine
- _____ Hep A - Hepatitis A Vaccine
- _____ Hep B - Hepatitis B Vaccine
- _____ IPV - Inactivated Polio Vaccine
- _____ MMR - Measles, Mumps, and Rubella Vaccine
- _____ Rotavirus (infants 6 - 32 weeks of age)
- _____ Pneumonia Vaccine (Prevnar) (under age 5 years)
- _____ Varicella (chickenpox) Vaccine
- _____ Influenza (Flu)
- _____ COVID-19:
 - _____ Pfizer _____ Moderna
 - _____ Other, specify _____

These vaccines may be given as combination vaccinations as provided by manufacturers.

My child has the following allergies (medication and/or food):

I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) or the appropriate Important Information Statement(s) about the disease(s) and vaccine(s) indicated above. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated above be given to me or the person named above for whom I am authorized to make this request.

I give permission for my child to receive the above-checked immunizations.

_____ **Name** _____ **Relationship to child**

_____ **Signature** _____ **Date**

