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PERMISSION FOR IMMUNIZATION

For Children ages 7 through 17 years

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

Check all vaccines your child needs at this time:

- ☐ Tdap - Tetanus, Diphtheria, and Acellular Pertussis Vaccine (ages 11 to 64 years)
- ☐ HPV - Human Papillomavirus (after age 9 years)
- ☐ Hep A - Hepatitis A Vaccine
- ☐ Hep B - Hepatitis B Vaccine
- ☐ IPV - Inactivated Polio Vaccine
- ☐ MMR - Measles, Mumps, and Rubella Vaccine
- ☐ Meningococcal Vaccine (Menactra)
- ☐ 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**