



Annual Immunization Consent Form

Patient Name: _____ Date of Birth: _____

I understand that it is medically recommended that my child receive immunizations as per the Center for Disease Control (CDC) immunization schedule and the American Academy of Pediatrics (AAP) guidelines.

I understand that each vaccine will be discussed with me prior to administration. I will be provided the Vaccine Information Statement for each vaccine and will be given the opportunity to ask questions.

The Vaccine Information Sheet(s) (VIS) from the CDC explain the vaccine(s) and the disease(s) they prevent. I will have the opportunity to discuss these with my child's doctor or nurse, who will answer all of my questions regarding the recommended vaccine(s), and the following information:

- The **purpose** of and the **need** for the recommended vaccine(s)
- The **risks** and **benefits** of the recommended vaccine(s)
- If my child does not receive the vaccine(s), the **consequences** may include:
 - Contracting the illness the vaccine should prevent (the outcomes of these illnesses may include one or more of the following: pneumonia, illness requiring hospitalization, death, brain damage, meningitis, seizures and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well)
 - Transmitting the disease to others
 - Requiring my child to stay out of child care or school during disease outbreaks
- My child's Physician or Nurse Practitioner, the American Academy of Pediatrics and the Centers for Disease Control all strongly recommend that these vaccines be given according to recommendations

I understand that by signing this form, I give consent for my child to receive recommended immunizations as per the CDC immunization schedule, including the influenza vaccine. ***I will be consulted on each vaccine prior to administration and I will have the opportunity to decline the vaccination if I choose to do so.*** While I will be given specific information for each vaccine, I will not need to sign individual consents for each vaccine. This consent will be renewed each year.

I understand that I may address this issue with my child's Physician or Nurse Practitioner at any time and that I may re-visit decisions on immunization for my child anytime in the future.

I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

IMMUNIZATION CONSENT IN THE ABSENCE OF PARENT OR GUARDIAN

I understand that this consent covers all routine, recommended immunizations, unless otherwise specified by me. This includes visits during which my child is not accompanied by a legal guardian.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____
