

Consent for Immunization Administration

Patient name: _____ DOB: _____

By signing below you authorize UCFS to administer the following vaccines in accordance with the State of Connecticut requirements for school entry. I understand the risks and benefits of this/these vaccine(s) and have had an opportunity to ask questions which were answered to my satisfaction and consent for my child to have the following vaccines.

Signature of parent or guardian _____

TDAP _____ Lot# _____

Polio _____ Lot# _____

Hepatitis B _____ Lot# _____

Hepatitis A _____ Lot# _____

MMR _____ Lot# _____

Menactra _____ Lot# _____

HPV _____ Lot# _____

Varicella _____ Lot# _____

Men B _____ Lot # _____

VIS given _____ Administered by: _____

