UCFS Healthcare
Well-Being Redefined.

United Community & Family Services
School Based Health Center
Telephone 860-822-2803
Fax 860-947-3716
Email: sbhc@ucfs.org

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 the opportunity to ask questions which were answered to my satisfaction and consent for my child to have the following vaccines.

Required Vaccines	Vaccine Name	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
	TDaP					
	Hep B					
	MMR					
	HPV					
	Men B					
	Hib					
	Td					

Required Vaccines	Vaccine Name	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
	Polio					
	Hep A					
	MedQuadfi					
	Varicella					
	DTaP					
	Prevnar					
	Kinrix					
	Other					

Parent or Guardian Name Printed _____

Signature of Parent or Guardian _____

Date Signed _____