

PLEASE SIGN AND RETURN THIS FORM AFTER READING
THE VACCINE INFORMATION STATEMENT (VIS).

"I have read or have had explained to me the information in this VIS about _____ . 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 ask that the vaccine(s) checked below be given to me or my child."

POR FAVOR FIRME Y DEVUELVA ESTA FORMULARIO TRÁS HABER LEÍDO
EL FOLLETO DE INFORMACIÓN SOBRE VACUNAS.

"Yo he leído ó me han explicado la información en la declaración de información de vacunas acerca de la(s) vacuna(s) para _____. He tenido la oportunidad de hacer preguntas las cuales fueron contestadas a mi satisfacción. Creo entender los beneficios y riesgos de la(s) vacuna(s) y pido que se administre(n) a mi ó a mi niño la(s) vacuna(s) indicada abajo."

- Vaccine to be given:
- | | | | |
|--------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> DTap | <input type="checkbox"/> Hib | <input type="checkbox"/> Pneumococcal | <input type="checkbox"/> Td |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Tdap |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Meningococcal | <input type="checkbox"/> Shingles | <input type="checkbox"/> Varicella (Chicken Pox) |
| | <input type="checkbox"/> MMR | <input type="checkbox"/> Rubella | <input type="checkbox"/> Other: |

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print)

NAME: Last	First	Middle Initial	Birth Date	Age
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Signature of person to receive vaccine or person authorized to make the request (parent or guardian):

Firma de la persona que recibirá la vacuna ó persona autorizada para solicitarla (Padre ó tutor):

X **Date:**

- I hereby DO NOT GIVE the facility permission to administer the vaccination.
 Por medio de la presente NO DOY permiso al hospital de administrar la vacunación.

Patient or legal representative's signature: _____ Date: _____
Paciente o la firma de representante legales _____ Fecha _____

Nurse's signature: _____ Date: _____

For Hospital/ Office Use Only

Date Vaccine Administered	Facility Where Administered
Vaccine Manufacturer	Signature of Vaccine Administrator
Vaccine Lot Number	Title of Vaccine Administrator
Date VIS Given	VIS Edition Date

FACILITY NAME

PATIENT IDENTIFICATION

VACCINE ADMINISTRATION RECORD
Record de Administration De Vacuna

WHITE-Patient Copy

YELLOW-Chart Copy