Martin's Point

Pediatric Vaccine Administration Consent Form

Person receiving vaccine: (**please check the box next to all that apply**)

☐ is enrolled in Medicaid ☐ has insurance

☐ is an Native American or Alaskan Native ☐ agrees to participate in IMMPACT (Maine Locations) or NHIIS (NH Locations)

I have read, or have had explained to me, information about the diseases and the vaccines indicated below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request).

I understand my insurance will only pay for services that it determines to be reasonable and/or medically advisable. If my insurance determines that a particular service, although it would otherwise be covered, is not reasonable and/or necessary by its standards, payment for that service may be denied. My insurance may deny payment for the immunization(s) listed below and the injection fee to give them.

If my insurance denies payment I agree to be personally and fully responsible for payment. Initials _____

Vaccine	Number In Series	Manufacturer Lot# and Expiration	Admin Site and Route
☐ Dtap			
☐ DTapIPV (Kinrix®)			
☐ Hepatitis A			
☐ Hepatitis B			
☐ HIB			
☐ IPV (Polio)			
☐ MenB (Bexero®, Trumenba®)			
☐ MenQuadfi			
☐ MMRV (Proquad®)			
☐ Pentacel®			
☐ Prevnar 20®			
☐ Rabies			
☐ Rotavirus			
☐ Td			
☐ Typhoid			
☐ Other			
REVIEW SPECIAL VACCINE ADMINISTRATION REQUIREMENTS FOR THE FOLLOWING			
☐ HPV			
☐ MMR			
☐ Tdap			
☐ Varicella			
☐ Yellow Fever			

**Medicare ABN, Medicare Advantage ODN, Notice of Non-Coverage, or Self-Pay Waiver REQUIRED
For Females Only: My provider has counseled me about the risk of pregnancy now and within the next 30 days.

Patient name: _____

Patient signature: _____ Date: _____

Administered by: _____

☐ **Order entered** ☐ **Med record updated**