**GREAT RIVER PEDIATRIC CLINIC  
Annual Immunization Consent Form**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

The Vaccine Information Sheet(s) (VIS) from the Centers for Diseases Control (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 ofand the need for the recommendedvaccine(s)
* The risks and benefits of the recommended vaccine(s).
* If the child does not receive the 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 illness 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 doctor or nurse, the American Academy of Pediatrics, the American Academy of Family Physicians, 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 vacci11e. While I will be given specific Information for each immunization, I will not need to sign individual consents for each vaccine. This consent will be renewed each year.

I understand that l may address this issue with my child's doctor or nurse 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. The Vaccine information Sheet will be given to be taken home.

**Parent/Guardian Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_