Pediatric Permission to Vaccinate

I have read or had explained to me the information about the following checked vaccines. I received the vaccine information statement (VIS) I have had a chance to ask questions and they have been answered to my satisfaction. I understand the benefits and risks of the vaccines checked below and ask that they be given to me or to the person named below for whom I am authorized to make this request.

Vaccine to be Given	VIS Publication Date	Date VIS Given	Language (if other than English)
☐ Hepatitis A			
☐ Hepatitis B			
☐ Human Papillomavirus (Gardisil)			
☐ Influenza-IIV (inactivated – intramuscular)			
☐ Measles, Mumps, Rubella (MMR)			
☐ Meningococcal conjugate- MCV4			
☐ Polio			
☐ Tetanus, Diphtheria (Td)			
☐ Tetanus, Diphtheria, Acelluar Pertussis (Tdap)			
☐ Varicella (Chickenpox)			
☐ Tuberculosis (TB Test)			
☐ Men B			
☐ Covid			

Name of person to receive vaccine (print): _____ Age/DOB: _____

Signature (if minor, signature of parent or guardian): _____

Date Consent Signed: _____ Date Vaccine Given: _____

Patient Vaccine for Children (VFC) Status Screening Form

Vaccines for Children (VFC) was established in 1993 to remove the barriers of cost and access to attaining childhood immunizations. The program supplies vaccines to providers across the state and is funded by the Centers for Disease Control and Prevention (CDC) and the State of Washington. Almost 95% of public and private immunization providers in King County are currently enrolled. All children from birth up to the 19th birthday (hepatitis B up to the 20th birthday) are eligible to receive these vaccines.

Form must be completed for every child under age 19 years. Form must be completed at each immunization visit. This form is kept for documentation purposes and must be kept on file as required by CDC guidelines. Responses do not dictate whether or not immunizations are given. We do not bill insurance at our office.

Patients VFC Eligibility Status Is: (Please select patient's health insurance category)
(If you have private insurance, please fill out policy and group number below)

- ☐ Private Health Insurance (Patient has private/commercial health insurance)
- ☐ WA State Medicaid (Patient has Washington State Apple Health Insurance, Healthy Options, fee for service)
- ☐ Uninsured (Patient currently does not have insurance)
- ☐ Underinsured (Patient has Insurance that has limited or no coverage for vaccines)
- ☐ American Indian or Alaska Native (Patient is American Indian or Alaska Native)

Name of Insurance: _____

Policy Number:_____ Group Number:_____