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Infant and Child Vaccine Consent-DTAP

Printed Patient Name: _____

Patient DOB: _____Date: _____MA Initials: _____

Vaccine Information:

Today you are receiving the following vaccination: _____

Lot Number: _____ Expiration Date: _____

Vaccines may be a **single dose** or require **multiple doses** over the course of months or years. Please make sure that you understand the requirements of the particular vaccine you or your child are receiving today before you leave the office.

The Pediatric **DTAP** vaccine is given in 5 (5) doses over the course of 4 to 6 years. Your schedule should adhere to the following interval:

- Dose at 2 months of age
- Dose at 4 months of age
- Dose at 6 months of age
- Dose at 15-18 months of age
- Dose at 4-6 years of age

First dose: _____Second dose: _____Third dose: _____
2 months old 4 months old 6 months old

Fourth dose: _____Fifth dose: _____
15 – 18 months old 4 – 6 years old

I have read the patient information sheet and would like to receive this vaccination. If the costs of the vaccine, and/or with any administration fees, are not covered by my Health Insurance Company, I and/or my parent/guardian agree to pay for the full price of the vaccine and its administration at the time of the first dose. I understand that if the intended recipient of the HPV vaccination is outside of the ages 9-26 years old, it is unlikely that any insurance will cover the cost of either fee.

_____

Patient/Parent/Guardian/Responsible Party Date