Consent for Child Immunization Form

_____ _____
PRINT NAME OF MINOR CHILD Date of Birth

_____ _____ _____
Address City State

_(_____)_____
Phone number

As the parent/legal guardian of the above named child, I have been informed that my child needs one or more vaccines which are identified below. I have had the opportunity to read the Vaccine Information Statement(s) for the vaccine(s) recommended for my child, and I understand the risks and benefits of my child receiving these vaccine(s). I give my consent for my son/daughter to be given the following vaccine(s) by New Horizons Solutions,Inc.™ (NHS) at:

_____ on _____
School or location Date of vaccination

The vaccine(s) circled below is/are recommended for my child. I have entered my initials next to the vaccine(s) that I am giving my permission for the NHS staff to give:

DTaP (___) IPV (___) MMR (___) Varicella (___) HIB (___) HepA (___) HepB (___)

RV (___) PCV (___) MCV (___) Flu (___) Tdap (___) HPV (___)

I agree to monitor my child for fever or other medical conditions that may arise after vaccination and to notify my child's physician if my child becomes ill after receiving the vaccine(s).

My child's physician is _____

The name of my child's physician's practice is: _____

Parent/legal guardian name (print): _____

_____ _____
Signature Date

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