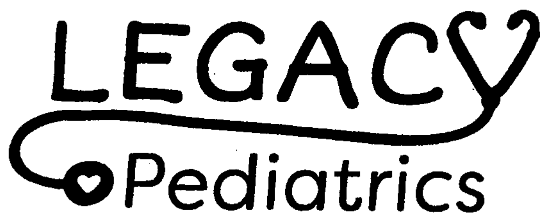

Janet R. Casey, M.D.
Alice L.Taylor, M.D.
Kate Shand, PA-C, IBCLC
Kristin Campe, PA-C, LCSW

Adult Vaccine Consent Form

Name ______________________________ **DOB** ____________

Physicians Name ______________________________

Physicians phone number ______________ **Fax Number** ______________

Insurance name if different then your child's ______________________

Insurance subscriber ID if different then your child's ______________________

1. **Do you feel sick today or had a fever in the last 24 hours?** ______________
2. **Have you ever had any serious reactions to a vaccine in the past** ______________
3. **Are you pregnant or considering becoming pregnant in the next month?** ______________

I certify that I am the patient and at least 18 years of age. Further, I herby give my consent to the health care provider Legacy Pediatrics to administer the vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving the vaccine. I understand the risks and benefits with the vaccine and have received, read, and/or had explained to me the vaccine information statements on the vaccine that I have elected to receive. On behalf of myself I herby release and hold harmless Legacy Pediatrics from any and all liability or claims whether known or unknown arising out or in connection with, or in any way related to the administration of the vaccine. I understand that Legacy Pediatrics will submit the claim to the insurance I have listed above and that if it is not a covered benefit under my insurance then I will be billed and liable to pay for the vaccine.

The vaccine I am requesting to be given today is ______________________

Patient Signature ______________________________ **Date** ________