



UNIVERSITY MEDICAL CENTER
LUBBOCK, TEXAS

PLEASE ATTACH PATIENT LABEL OR PROVIDE:
NAME _____
MRN _____ FIN _____



Texas Department of State Health Services
Addendum to Your Baby's First Vaccines Vaccine Information Statement

1. I agree that the person named below will get the vaccines checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccines listed below.
3. I know the risks of the diseases the vaccines prevents.
4. I know the benefits and risks of the vaccines.
5. I have had a chance to ask questions about the diseases the vaccines prevent, the vaccines, and how the vaccines are given.
6. I know that the person named below will have the vaccines put in his/her body to prevent the diseases the vaccines prevent.
7. I am an adult who can legally consent for the person named below to get the vaccines. I freely and voluntarily give my signed permission for these vaccines.

Vaccine(s) to be given: Hepatitis B (HepB) Polio (IPV) Pneumococcal Disease (PCV13)
 Diphtheria, Tetanus, & Pertussis (DTaP) *Haemophilus influenzae* type b (Hib)

Information about person to receive vaccine (Please print)				
Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one)
				<input type="radio"/> M <input type="radio"/> F
Address: Street	City	County	State	Zip
			TX	
Signature of person to receive vaccine or person authorized to make the request (parent or guardian):				
X _____			_____	Date
_____			_____	Date
Witness				

For Clinic/Office Use Clinic/Office Address:
Vaccine Given:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

For Clinic/Office Use Clinic/Office Address:	For Clinic/Office Use Clinic/Office Address:	For Clinic/Office Use Clinic/Office Address:	For Clinic/Office Use Clinic/Office Address:	For Clinic/Office Use Clinic/Office Address:
Vaccine Given:	Vaccine Given:	Vaccine Given:	Vaccine Given:	Vaccine Given:
Date Vaccine Administered:	Date Vaccine Administered:	Date Vaccine Administered:	Date Vaccine Administered:	Date Vaccine Administered:
Vaccine Manufacturer:	Vaccine Manufacturer:	Vaccine Manufacturer:	Vaccine Manufacturer:	Vaccine Manufacturer:
Vaccine Lot Number:	Vaccine Lot Number:	Vaccine Lot Number:	Vaccine Lot Number:	Vaccine Lot Number:
Site of Administration:	Site of Administration:	Site of Administration:	Site of Administration:	Site of Administration:
Signature of Vaccine Administrator:	Signature of Vaccine Administrator:	Signature of Vaccine Administrator:	Signature of Vaccine Administrator:	Signature of Vaccine Administrator:
Title of Vaccine Administrator:	Title of Vaccine Administrator:	Title of Vaccine Administrator:	Title of Vaccine Administrator:	Title of Vaccine Administrator:

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

Instructions: File this consent statement in the patient's chart.

