



Community Health Centers

Healthcare For Life

Immunization Services Record of Consent

1. I agree that the person named below will receive vaccine(s) suggest by the physician.
2. I will receive a copy of the Vaccine Information Statement (VIS) after every immunization.
3. The benefits and risks of the vaccine to be administered will be explained before every vaccine.
4. I have the right to ask questions about the disease, the vaccine, and how the vaccine is given.
5. I am a parent or legal guardian who can legally consent for that person named below to get the vaccine(s). I freely and voluntarily give my signed permission for each vaccine.

Consent for the California Automated Immunization Registry (CAIR)

I authorize the California Automated Immunization Registry to release immunization records only, if needed on my child to any of the following:

- a. Local Health Department
- b. A physician requesting Immunization records
- c. School in which the child is enrolled.
- d. Child Care Facility in which the child is enrolled.

INFORMATION about the person to receive vaccine:

Last Name _____ MI _____ Name _____
 Date of Birth _____ Male _____ Female _____
 Street Address _____ Phone# _____
 City _____ State _____ Zip Code _____
 Mother's First Name _____

Other family member(s) given permission to bring child in for immunizations:

Name _____ Relationship to child _____
 Name _____ Relationship to child _____

Please circle the category which best describes the child's payment status

1. CHDP/Cen-Cal# _____
2. Without insurance
3. Am. Indian/Native American
4. Insurance does not cover IZ
5. Not eligible (ex: Healthy Families, BX, BS)

 Signature of parent Relationship to child Date

CAIR#	Medical Record #	Disclosing Staff: