The Physician Network
2000 Q Street Suite 500
Lincoln, NE 68503

IMMUNIZATION PROXY FORM

I received a copy of the Vaccine Information Statement(s) which I read or had explained to me for the vaccine(s) checked below:

❑ Tetanus/Diphtheria/Pertussis (Tdap)	❑ Meningococcal (MCV)	❑ Hepatitis A (HepA)
❑ Rotavirus (RV)	❑ Influenza	❑ Hepatitis B (HepB)
❑ Diphtheria/Tetanus/Pertussis (DTaP)	❑ Haemophilus Influenza type b (Hib)	❑ Pneumococcal Conjugate (PCV13)
❑ Tetanus/Diphtheria (Td)	❑ Inactivated Polio Vaccine (IPV)	❑ Varicella (VAR)
❑ Human Papillomavirus (HPV)	❑ Measles/Mumps/Rubella (MMR)	❑ PPD/Tuberculosis Skin Test

❑ Other:_____

I have had a chance to ask questions and have had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that they be given to the person named below for whom I am a parent or guardian.

Information about Person to receive vaccine (Please Print)

Name: Last	First	M.I.	Birthdate	Age

Address: Street	City	County	State	Zip

❑ Medicaid	❑ Uninsured	❑ Native American/Native Alaskan	❑ * Underinsured	❑ Other

Physician _____

Signature parent or guardian	Date

* Underinsured = Have insurance that does not cover vaccines.