

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Tetanus/Diphtheria/Pertussis (Tdap) | <input type="checkbox"/> Meningococcal (MCV) | <input type="checkbox"/> Hepatitis A (HepA) |
| <input type="checkbox"/> Rotavirus (RV) | <input type="checkbox"/> Influenza | <input type="checkbox"/> Hepatitis B (HepB) |
| <input type="checkbox"/> Diphtheria/Tetanus/Pertussis (DTaP) | <input type="checkbox"/> Haemophilus Influenza type b (Hib) | <input type="checkbox"/> Pneumococcal Conjugate (PCV13) |
| <input type="checkbox"/> Tetanus/Diphtheria (Td) | <input type="checkbox"/> Inactivated Polio Vaccine (IPV) | <input type="checkbox"/> Varicella (VAR) |
| <input type="checkbox"/> Human Papillomavirus (HPV) | <input type="checkbox"/> Measles/Mumps/Rubella (MMR) | <input type="checkbox"/> PPD/Tuberculosis Skin Test |
| <input type="checkbox"/> 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
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Uninsured	<input type="checkbox"/> Native American/Native Alaskan	<input type="checkbox"/> * Underinsured	<input type="checkbox"/> Other	
Physician _____					
Signature parent or guardian				Date	

* Underinsured = Have insurance that does not cover vaccines.