**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. 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.

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

### Information about Person to receive vaccine (Please Print)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
<th>Birthdate</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Street</td>
<td>City</td>
<td>County</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Uninsured</td>
<td>Native American/Native Alaskan</td>
<td>* Underinsured</td>
<td>Other</td>
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Physician ____________________________

Signature parent or guardian ____________________________ Date ____________

* Underinsured = Have insurance that does not cover vaccines.

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