

Vaccine Consent Form – Multiple Vaccines

This form serves as a record of your consent to receive vaccinations during your stay, based on the latest national guidelines and your eligibility.

- I, the undersigned, have received information about the risks and benefits of the vaccines listed below.
- I have had the opportunity to ask questions and have received answers to my satisfaction.
- I understand the vaccination process and freely consent to such process.
- I understand that I will be screened for eligibility prior to receiving any vaccine dose based on the recommended vaccine schedule by the National Advisory Committee for Immunization Practices (ACIP).
- I understand that I may change my mind about vaccination at any time prior to receiving the vaccine(s).
- I consent to the vaccine(s) selected below as indicated by circling “Yes” option. My signature also authorizes entry of the vaccination(s) into the State Immunization Registry if required.

Vaccine	Consent (Circle Yes or No)	
Influenza	Yes	No
COVID-19	Yes	No
Pneumococcal (PCV15, PCV20, or PPSV23)	Yes	No
Respiratory Syncytial Virus (RSV)	Yes	No
Shingles	Yes	No
Other Vaccines recommended by ACIP: such as Tetanus/diphtheria (DTaP) Must specify: _____	Yes	No

Signature of Resident or Legal Representative

Date & Time

****REVIEW AND SIGN NEXT PAGE****

If Legal Representative, print name and state relationship to Resident:

****If Legal Representative, please ensure receipt of a copy of the Healthcare Power of Attorney, Advance Directive, Letters of Guardianship, or other documents that authorize Resident Representative to execute this consent.**

Resident Name:	Birthdate:
Admission Date:	Medical Record #:
Physician:	