

Consent for Administration of Vaccination

Dear (Physician's Name): _____
If you will be administering a vaccination to me, or my child, today, I will need for you to complete the following consent form.
Thank you.

Responsible Physician Statement

I, (Physician Name) _____ do hereby state that I have advised my patient, (patient or child's name) _____ and/or parent of my patient, (parent's name) _____ that in my professional opinion this patient/child should be given the vaccination, drug or other (name of vaccination/drug/other) _____.
Manufacturer's name _____.
Serial number _____
Batch Number _____.

I have on this (day) _____ (month) _____ (year) _____ administered this vaccination/medication/drug AFTER advising the above named patient/parent of minor patient that there is little or no risk involved with this vaccination/medication/drug therapy or treatment. I hereby do agree that should this patient/child at anytime suffer or develop any permanent condition deleterious or injurious to his/her health as a result of this treatment, I will pay for any and all costs involved related to the care and treatment necessary for this patient/child for the rest of his/her natural life.

I further agree that if my earnings are insufficient to meet these costs, I will sell my home, my business and all material possessions and put those proceeds towards meeting the needs and expenses of the patient involved.

Date: _____

Signature of responsible physician: _____

Signature of responsible person administering vaccination/medication/drug: _____
Occupational Title: _____

Signature of Witness: Parent or other: _____