

Lewisville Family Physicians

CONSENT FOR IMMUNIZATION

You have been given information about the vaccines and the potential common and rare adverse effects. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed immunization.

Patient Name

Date

1. **Vaccine(s):** _____

2. **Risks/Benefits of Proposed Procedure(s): (General)**

Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.

3. **Complications; Unforeseen Conditions, Results:** I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

4. **Acknowledgments:** The alternative to immunization, specifically declining immunization, carries risks. The primary risks include contracting the infection (only for some live vaccines), and potentially spreading the infection to other unvaccinated persons. The infections for which there are vaccinations carry risks of severe impairment and possibly death. I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers. I have also read the Vaccine Information Statement for the particular vaccine(s) being given.

5. **Consent to Procedure(s) and Treatment:** Having read this form and talked with the physicians, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my physician and/or his/her associates assisted by trained personnel as well as the presence of observers. All my questions have been answered prior to giving this consent.

6. **Payment:** We will file for payment from your insurance. **If your insurance does not cover the immunizations, you will be responsible for payment.** It is your responsibility to know whether vaccines are covered by your insurance.

Patient
(or person authorized to sign for patient- please print name also)

Date

Witness

Date