

VACCINE CONSENT FORM

I hereby consent to receive the .

I have been informed and understand the following:

I have had the opportunity to ask questions and have received satisfactory answers regarding the vaccine's risks, benefits, and potential side effects. I have been informed about common side effects of the vaccine.

I understand that no vaccine is 100% effective, and that additional doses or booster shots may be recommended for optimal protection.

I have disclosed all relevant medical history, including allergies, current medications, and any history of severe allergic reactions, especially to vaccine components.

I acknowledge that I have been given the opportunity to refuse or defer the vaccination and that I have chosen to receive it voluntarily.

I understand that I can ask for more information or clarification at any time before, during, or after receiving the vaccine.

By signing below, I confirm that I have read and understood the information provided and consent to receive the .

Patient Information		
First Name	Last Name	Date of Birth

Signature:

Signature Date: