



Mason and Partners Clinic

Manassas Park Site

99 Tremont Street, Manassas Park, VA 20111

Phone: 703-993-5880; Email: MAPClinic@gmu.edu

Age: _____

VVFC Eligibility: VFC – Uninsured

VFC – Medicaid/Medicare

Not VFC Eligible

INFORMED CONSENT AND VACCINE ADMINISTRATION RECORD

_____ **DTaP** **IM** Site: _____

Lot: _____ Exp: _____

_____ **DTaP-IPV** (4-6 years old) **IM** Site: _____

Lot: _____ Exp: _____

_____ **Hepatitis A** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Hepatitis B** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Hib** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Human Papillomavirus (HPV)** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Influenza** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Meningococcal (ACWY)** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Measles, Mumps, Rubella (MMR)** **SQ** Site: _____

Lot: _____ Exp: _____

_____ **MMR-V** (12 years old and younger) **SQ** Site: _____

Lot: _____ Exp: _____

_____ **Pneumococcal Conjugate (PCV13)** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Polio (IPV)** **IM or SQ** (circle one) Site: _____

Lot: _____ Exp: _____

_____ **TDaP** **IM** Site: _____

Lot: _____ Exp: _____

_____ **Varicella** **SQ** Site: _____

Lot: _____ Exp: _____

_____ **TST-PPD Intradermal** Site: _____ Lot: _____ Exp: _____ Time Placed: _____ :

I have read, or have had read to me, the information regarding the vaccine(s) marked above. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I consent, or give consent for, the administration of the vaccine(s) marked above to:

Patient Name (print)

Date of Birth (MM/DD/YYYY)

Name of Parent/Guardian (print)

Signature

Date

Name of Vaccine Administrator (print)

Signature

Date