Community Health Centers
Healthcare For Life

Immunization Services
Record of Consent

1. I agree that the person named below will receive vaccine(s) suggest by the physician.
2. I will receive a copy of the Vaccine Information Statement (VIS) after every immunization.
3. The benefits and risks of the vaccine to be administered will be explained before every vaccine.
4. I have the right to ask questions about the disease, the vaccine, and how the vaccine is given.
5. I am a parent or legal guardian who can legally consent for that person named below to get the vaccine(s). I freely and voluntarily give my signed permission for each vaccine.

Consent for the California Automated Immunization Registry (CAIR)

I authorize the California Automated Immunization Registry to release immunization records only, if needed on my child to any of the following:

a. Local Health Department
b. A physician requesting Immunization records
c. School in which the child is enrolled.
d. Child Care Facility in which the child is enrolled.

INFORMATION about the person to receive vaccine:

Last Name_____ MI____ Name_____

Date of Birth_____ Male_____ Female _____

Street Address_____ Phone#_____

City_____ State_____ Zip Code_____

Mother's First Name_____

Other family member(s) given permission to bring child in for immunizations:

Name_____ Relationship to child_____

Name_____ Relationship to child_____

Please circle the category which best describes the child's payment status

1. CHDP/Cen-Cal#_____
2. Without insurance
3. Am. Indian/Native American
4. Insurance does not cover IZ
5. Not eligible (ex: Healthy Families, BX, BS)

_____ _____ _____

Signature of parent Relationship to child Date

CAIR#	Medical Record #	Disclosing Staff: