Marshall County Medical Clinic
Avera

Name:	Date of birth	Age:
Address:	Phone:	Gender (circle) Male Female

A copy of the appropriate CDC and Prevention Vaccine Information statement(s) has been provided. I have read or have had explained, the information about the disease(s) and the vaccines(s) listed below. There was opportunity to ask questions and all questions were answered satisfactorily. I believe and I understand the benefits and risks of the vaccine(s) cited and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request).

Signature:	Date:

VFC Eligibility: (Circle) Medicaid-eligible No insurance Underinsured (vaccines not covered by Health insurance)

American Indian

Insurance Information:

Policy Holder_____

Insurance company_____

Address_____

Policy Number_____

Signature of Guardian (if client is under 18 years of age) _____ Date _____

Office Use Only:

Vaccine	VIS date	Manufacturer	Lot Number	Expiration	NDC #
Tdap					
MCV 4					
Men B					
HPV					

Signature of Person Administering Vaccines:_____Date_____