Children's Hospital
New Orleans
LCMC Health

OUTPATIENT IMMUNIZATION AUTHORIZATION

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

Date: _____

I, _____, have received education from the ordering provider regarding the immunizations ordered below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the ordered vaccine(s) listed below and request that the vaccine(s) be given to the person named above for whom I am authorized to make this request.

VACCINE ORDERED	PARENT/GUARDIAN'S INITIALS
❑ Hepatitis B	
❑ DTaP	
❑ Haemophilus Influenzae Type B	
❑ Polio	
❑ Pneumococcal 13	
❑ Rotavirus	
❑ Hepatitis A	
❑ Measles/Mumps/Rubella	
❑ Varicella	
❑ Measles/Mumps/Rubella/Varicella	
❑ Tdap	
❑ Meningococcal	
❑ Human Papillomavirus - 9	
❑ Serogroup B Meningococcal	
❑ TD	
❑ Pneumococcal 23	
❑ Seasonal Influenza	
❑ Other:	
❑ Other:	

Patient / Legal Representative Signature: (Patient / Guardian if patient under 18 years of age or un-emancipated) X	**Initials:**	**Date** MM/DD/YY / /	**Time** 00:00 AM/PM :
Printed Name of Patient / Legal Representative :	**Relationship to patient:**		

Nurse Signature: X	**Date** MM/DD/YY / /	**Time** 00:00 AM/PM :