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James Austin Health Center  
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## VACCINE CONSENT FORM

### Information about person to receive vaccine:

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_ **Sex:**  Male  Female

**Race:**  Asian  Black  Native American  Pacific Islander  White  Other **Ethnicity:**  Hispanic  Non-Hispanic

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_-\_\_\_\_-\_\_\_\_ **Email:** \_\_\_\_\_

### Insurance Information:

Primary Insurer: \_\_\_\_\_ Insurance Holder: \_\_\_\_\_

Group/Individual ID Number: \_\_\_\_\_

Print Parent/Guardian name, if different from client: \_\_\_\_\_

Client/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_