NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

NEBRASKA IMMUNIZATION ADMINSTRATION PROXY FORM

I have been given a copy and have read or have had explained to me the information in the "Vaccine Information Statement(s) for the vaccine(s) checked below. I have had the chance to ask questions and have had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that they be given to the person named below *for whom I am parent or legal guardian.*

_____Tetanus/Diptheria/Acellular Pertussis (Tdap)
_____Tetanus/Diptheria (Td)
_____Hepatitis A (Hep A)
_____Hepatitis B (Hep B)
_____Meningococcal (MCV)
_____Human Papilloma (HPV)
_____Diptheria/Tetanus/ Acellular Pertussis (DTaP)
_____Rotavirus (RV)
_____Haemophilus Influenza B (HIB)
_____Pneumococcal Conjugate (PCV-13)
_____Measles/Mumps/Rubella (MMR)
_____Varicella (Var/VZV)
_____DTaP/IPV/Hepatitis B (Pediarix)
_____DTaP/IPV/HIB (Pentacel)
_____Dtap/IPV (Kinrix)
_____Influenza
_____Other _____

INFORMATION ABOUT THE PERSON **RECEIVING** THE IMMUNIZATION ***(PLEASE PRINT)**

Name: Last First Middle			**Birthdate**	**Age**
Address: Street	**City**	**County**	**State**	**Zip**
Please Circle One: Medicaid Uninsured * Underinsured				
Native American/Native Alaskan Other				
Signature of Parent or Legal Guardian				**Date**
X				
***Underinsured: Patients insurance does not cover immunizations.**				
This proxy form is valid for only TWO WEEKS from date of parent signature.				