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)

_____Hepatitis A (Hep A)

_____Meningococcal (MCV)

_____Diptheria/Tetanus/ Acellular Pertussis (DTaP)

_____Haemophilus Influenza B (HIB)

_____Measles/Mumps/Rubella (MMR)

_____DTaP/IPV/Hepatitis B (Pediarix)

_____Dtap/IPV (Kinrix)

______Other

_____Tetanus/Diptheria (Td)

_____Hepatitis B (Hep B)

_____Human Papilloma (HPV)

_____Rotavirus (RV)

_____Pneumococcal Conjugate (PCV-13)

_____Varicella (Var/VZV)

_____DTaP/IPV/HIB (Pentacel)

_____Influenza

_____Covid

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

Name: Last	**First**	**Middle**	**Birthdate**	**Age**

Address: Street	**City**	**County**	**State**	**Zip**

Please Check One: **Medicaid____** **Uninsured____** ***Underinsured____**
Native American/Native Alaskan____ **Private Insurance____**
***Underinsured: Patients insurance does not cover immunizations**

Childs Legal Guardian's Printed Name **Date:**

Signature of Parent or Legal Guardian **Phone Number:**

This proxy form is valid for only TWO WEEKS from date of parents' signature.

Revised 5/11/23