CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Sports Physical Clinic Immunization Consent Form

I, _____ (Child's parent or legal guardian), give permission for _____ (Child's name and date of birth) to receive immunizations at the Sports Physical Clinic on August 19, 2019. I give permission for my child to get:

Please mark ALL immunizations you would like your child to receive:

- ☐ Meningococcal
- ☐ Tdap
- ☐ HPV

I have reviewed the Vaccine Information Sheets (VIS) which have been made available to me at the Cascade Medical website, cascademedical.org. Initial _____

Signature of parent or legal guardian: _____ Date: _____