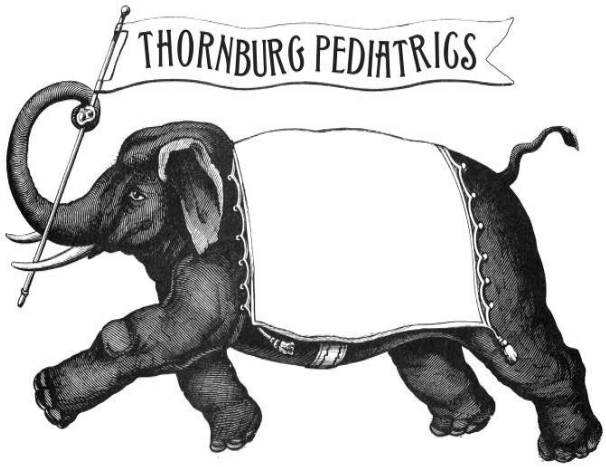

Patient's Last Name:

Patient's First Name:

Birth date:

A copy of the appropriate Center for Disease Control and prevention Vaccine Information Statements has been provided. I/We have read, or have had explained, the information about the diseases and the vaccines. I/We agree to the schedule discussed with Dr. Thornburg for administration of these vaccines. I/We understand that this authorization will be in effect until the time I/We decide to revoke this authorization.

I ask that the vaccine(s) discussed with Dr. Thornburg be given to the person named above for whom I am authorized to make this request.

_____/_____

Signature of Patient or Parent/Guardian Relationship

_____

Date of consent