



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: _____