Deansgrange Medical Centre
2 Clonkeen Road, Blackrock,
Co. Dublin.

Immunisation Consent Form

Patient's name & DOB: (place addressograph here)

Lot Number: **Expiry date:**

Lot number: **Expiry date:**

Lot number: **Expiry date:**

I have been fully informed about the above vaccine/s and which disease/s it/they provide/s protection against, the possible side effects, when they might occur and how they should be treated. I confirm by signing this form that I'm authorising consent for the administration of this/these vaccine/s to me.

Patient's signature: _____ Date: _____

Administered by: _____ Date: _____

Prescribed by: _____ Date: _____