**POST EXPOSURE** VACCINE ADMINISTRATION
VISIT RECORD and CONSENT STATEMENT

I have read or have had explained to me the information on this form about **POST EXPOSURE** rabies treatment and received a copy. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of rabies vaccine and agree to assume such risks. I ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

| Information about person to receive vaccine (Please Print) | | | | |
|---|---|---|---|---|
| Name: Last | First | Middle Initial | Birth date | Age |
| Address: House number, Street | City | County | State & Zip | |
| Signature of person to receive vaccine or person authorized to make the request:<br><br>X _____ Date: _____ | | | | |

| For Clinic/Office Use | | | | | | |
|---|---|---|---|---|---|---|
| Body weight: | lbs<br>kg | Vaccine DAY 0 | Vaccine DAY 3 | Vaccine DAY 7 | Vaccine DAY 14 | Vaccine DAY 28 **Immunocompromised Only** |
| Vaccine Given (Circle one) | Human Rabies Immune Globulin | RabAvert<br>HDCV<br>RVA | RabAvert<br>HDCV<br>RVA | RabAvert<br>HDCV<br>RVA | RabAvert<br>HDCV<br>RVA | RabAvert<br>HDCV<br>RVA |
| Date Administered | | | | | | |
| Vaccine Manufacturer | | | | | | |
| Vaccine Lot Number | | | | | | |
| Site & Route of Injection | | | | | | |
| Signature & Title | | | | | | |

**Health Care Provider Name** _____

**Health Care Provider Address** _____