PRE-EXPOSURE VACCINE ADMINISTRATION
VISIT RECORD and CONSENT STATEMENT

I have read or have had explained to me the information on this form about **PRE-EXPOSURE** rabies vaccination 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:

X _____ Date: _____

For Clinic / Office Use

	Vaccine **DAY 0**	Vaccine **DAY 7**	Vaccine **DAY 21 OR DAY 28**
Vaccine Given (Circle one)	PCEC HDCV RVA	PCEC HDCV RVA	PCEC HDCV RVA
Date Administered			
Vaccine Manufacturer			
Vaccine Lot Number			
Site & Route of Injection			
Signature & Title			

Health Care Provider Name _____

Health Care Provider Address _____

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