* 312599w15138 A-Consent

SUNSHINE
PEDIATRIC CLINIC

Consent for Procedure/Treatment

Patient:
DOB: 12/02/2014
Address: 199 ULULANI ST
HILO, HI 96720

Date:
Patient ID: 2674

I hereby authorize and direct Dr. Shallon Craddock and assistants, as necessary to perform quality care, to perform the following procedure/treatment(s) on me:

– _____

I have been provided a Vaccine Information Sheet (VIS) on the nature and purpose of the vaccine, and I understand the potential risks and complications.

– _____

– _____

– _____

Time of service: _____

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____

Date: _____