



I, \_\_\_\_\_ give permission for my son/daughter \_\_\_\_\_

DOB (of patient): \_\_\_\_\_ to receive the following immunizations today.

\_\_\_\_\_

(The immunizations have to be clearly documented on this form in order for them to be administered.)

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
(Please Print)

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Pediatric & Adolescent Medicine*