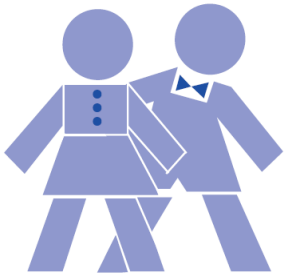

GLENS FALLS PEDIATRICS CONSULTANTS PC
PEDIATRIC ASSOCIATES OF SARATOGA

PERMISSION TO ADMINISTER VACCINES

Patient's Name _____ DOB: _____

I give permission for the following immunizations to be given at the office visit on (Date)_____

- □ Hepatitis B vaccine
- □ Diphtheria, Tetanus, acellular Pertussis (DTaP) vaccine
- □ Diphtheria Tetanus (DT or dT) vaccine
- □ Haemophilus influenzae type B (Hib) vaccine
- □ Pneumococcal conjugate vaccine
- □ Polio vaccine (IPV)
- □ Rotarix
- □ Measles, mumps, rubella (MMR) vaccine
- □ Varicella (chickenpox) vaccine
- □ Influenza (flu) vaccine
- □ Meningococcal ACWY vaccine
- □ Meningococcal B vaccine (MenB)
- □ Hepatitis A vaccine
- □ HPV (Gardasil)
- □ Other: _____

Please Print Name of Parent/Legal Guardian _____

Signature of Parent/Legal Guardian: _____

Relationship to the patient: _____ Date: _____