Van Dorn Pediatrics, P.C.

Child's Name _____ *DOB* _____

Child's Name _____ *DOB* _____

Child's Name _____ *DOB* _____

Child's Name _____ *DOB* _____

Re: Immunizations/ Injections

It is our duty to protect each of our patients to the best of our ability, this means having fully immunized patients. I give the staff permission to administer routine immunizations and to provide antibiotics for my child. I understand that printed handouts regarding vaccines will be given to me at the time of my child's immunizations. I also understand that the staff will answer any questions I have at the time of administration.

Legal guardians who are not able to abide by our guidelines will be asked to find a medical practice that is able to comply with their beliefs.

_____ _____

Signature of parent Date *Date*

Over→

Van Dorn Pediatrics, P.C.

_____

I give my permission to the staff of Van Dorn Pediatrics to see and to treat my child when the following people bring them to the office:

*Name (**other than Parents**)*	*Relationship to child*
_____	_____
_____	_____
_____	_____
_____	_____

_____

Signature

_____

Date