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**Golden Gate Pediatrics**  
*A Medical Corporation*

**Vaccine Administration Permission**

If your child is going to be coming in to the office to receive immunization(s) and a parent or legal guardian isn't going to be present, please check the appropriate box(es) below, sign, and give to your child to bring to the office at the time of administration.

Thank You!

I give permission for my child to receive the following vaccines from Golden Gate Pediatrics:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> DTaP(diphtheria, tetanus & pertussis) | <input type="checkbox"/> HIB (haemophilus influenzae type b)     | <input type="checkbox"/> DTaP/Hib                   |
| <input type="checkbox"/> IPV (polio)                           | <input type="checkbox"/> DTaP-IPV/Hib                            | <input type="checkbox"/> Pneumococcal               |
| <input type="checkbox"/> MMR (measles, mumps, rubella)         | <input type="checkbox"/> Varicella (chickenpox)                  | <input type="checkbox"/> MMRV                       |
| <input type="checkbox"/> Hepatitis A                           | <input type="checkbox"/> Hepatitis B                             | <input type="checkbox"/> HPV (Human Papillomavirus) |
| <input type="checkbox"/> Rotavirus                             | <input type="checkbox"/> Influenza                               | <input type="checkbox"/> PPD (tuberculosis test)    |
| <input type="checkbox"/> Meningococcal                         | <input type="checkbox"/> Tdap (tetanus, diphtheria, & pertussis) |   |

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_