Golden Gate Pediatrics
A Medical Corporation

Vaccine Administration Permission

If your child is going to be coming into the office to receive immunization(s) and a parent or legal guardian will not 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 or submit ahead of time via the patient portal.

Thank You!

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

☐ DTaP(diphtheria, tetanus & pertussis)	☐ DTaP-IPV/Hib	☐ DTaP-IPV-Hib-Hep B
☐ IPV (polio)	☐ DTaP-IPV	☐ Meningococcal
☐ MMR (measles, mumps, rubella)	☐ Varicella (chickenpox)	☐ Meningococcal B
☐ Hepatitis A	☐ Hepatitis B	☐ MMRV
☐ Rotavirus	☐ Td (tetanus & diphtheria)	☐ Pneumococcal
☐ HIB (haemophilus influenzae type b)	☐ Tdap (tetanus, diphtheria, & pertussis)	☐ PPD (tuberculosis test)
☐ Typhoid	☐ HPV (Human Papillomavirus)	

Child's Name _____ Date of Birth _____

Parent/Guardian Name: _____

Parent/Guardian Signature _____ Date _____