

PEDIATRIC SPECIALISTS OF THE NORTHWEST, MDSC

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**Vaccine
Authorization**

Patient's Name

Date of Birth

I authorize Pediatric Specialists of the Northwest (PSNW) to vaccinate my child when coming to the office without a legal guardian present.

This includes the following vaccines as marked

PLEASE NOTE OUR POLICY REGARDING ALL VACCINES:

- **PATIENTS RECEIVING *GARDASIL* AND MENINGITIS VACCINES MUST WAIT 20 MINUTES AFTER THEY ARE VACCINATED BEFORE LEAVING.**
- **PATIENTS 17 AND UNDER MUST BE PICKED UP BY ANOTHER DRIVER FOR ALL VACCINES; MINORS WHO ARE OF DRIVING AGE WILL NOT BE ALLOWED TO DRIVE THEMSELVES FROM THE APPOINTMENT.**

- | | |
|--|--|
| <input type="checkbox"/> Tdap | <input type="checkbox"/> Dtap |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> IPOL |
| <input type="checkbox"/> Varivax | <input type="checkbox"/> Hib |
| <input type="checkbox"/> Gardasil series of 3 | <input type="checkbox"/> Hepatitis B series of 3 |
| <input type="checkbox"/> Hepatitis A series of 2 | <input type="checkbox"/> Prevnar |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> MMR |
| <input type="checkbox"/> Combination
Dtap/Polio | <input type="checkbox"/> _____ |

I acknowledge that PSNW has provided me with the corresponding CDC Vaccine Information Sheets (VIS) as marked above. I further acknowledge that I have read these sheets and understand the risks and benefits.

Signature

Date

Printed Name

Relationship to Patient