DOWNTOWN PEDIATRICS
36 N. Moore Street
New York, NY 10013
(212) 925-3636
Fax: (212) 925-0633

VACCINE AUTHORIZATION FORM

I, _____ (parent or guardian),
allow_____ (patient), to receive the following vaccine(s)/injections while accompanied by_____.

- ☐ Seasonal flu 0.25ml preservative-free injectable vaccine
- ☐ Seasonal flu 0.5ml injectable vaccine
- ☐ Seasonal flu nasal mist
- ☐ DTaP
- ☐ Haemophilus influenza B (HIB)
- ☐ Pneumococcal vaccine
- ☐ Pentacel (DTaP-HIB-IPV)
- ☐ Pediarix (DTaP-HepB-IPV)
- ☐ Kinrix (DTaP and IPV combo)
- ☐ Hepatitis A
- ☐ Rotavirus
- ☐ Polio
- ☐ Hepatitis B
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Proquad (MMR and Varivax combo)
- ☐ Varicella (Chicken Pox)
- ☐ HPV (Human Papilloma Virus)
- ☐ Tdap
- ☐ Menactra (Meningococcal)
- ☐ Synagis

If needed I can best be reached at: _____
Parent/Guardian_____
Date (of visit)_____