Patient Name: DOB: Chart #:

happy kids pediatrics

Combination Vaccines

- ☐ Pentacel (DTaP/Hib/IPV)
- ☐ Pediarix (DTaP/HepB/IPV)
- ☐ Kinrix (DTaP/IPV)
- ☐ Quadracel (DTaP/IPV)
- ☐ ProQuad (MMR/VAR)
- ☐ Comvax (Hib/HepB)

Flu Vaccines

- ☐ Flu Mist (2yrs-18Yrs)
- ☐ .25 (6mth-35mth)
- ☐ .5 (3yrs-18Yrs)
- ☐ .5 (6mos-18Yrs)

Individual Vaccines

- ☐ DTaP
- ☐ Hib
- ☐ PCV13
- ☐ RV1 (Rotarix)
- ☐ RV5 (RotaTeq)
- ☐ IPV
- ☐ HepB
- ☐ HepA
- ☐ MMR
- ☐ Varicella
- ☐ TDaP
- ☐ HPV
- ☐ MCV4
- ☐ MenB

By signing below I authorize all vaccines check marked above to be administered to my son/daughter designated on this form.

Por medio de mi firma, autorizo que las vacunas indicadas sean administradas a mi hijo/hija.

Parent / Legal guardian

(Print)________________________________Signature___________________________