VACCINE AUTHORIZATION FORM

I, _____, hereby authorize the
Print Name of Parent or Guardian

office of Niranjana Rajan, M.D, P.A. to administer immunizations to my child according to the schedule set forth by the American Academy of Pediatrics. The office of Niranjana Rajan, M.D., P.A. will provide information regarding each immunization, including risks and benefits. The Parent/Guardian will have the opportunity to ask questions and discuss the administration of vaccines to my child. If there is an immunization which the Parent/Guardian does not wish their child to receive then a Refusal To Vaccinate Form will be signed for that particular vaccine.

Patient:_____

Date of Birth: _____

Signature of Parent/Guardian:_____

Date:_____