St. Louis Pediatric Associates, Inc.
226 S. Woods Mill Rd. 32W • Chesterfield, MO 63017
Phone (314) 576-1616 • *Fax* (314) 576-5271

I, _____, authorize St. Louis Pediatric Associates, Inc. to administer the vaccines marked below to my child, _____(DOB:_____) as recommended by my pediatrician. I also agree to read the Vaccine Information Sheet(s) on the St. Louis Pediatric Associates website (www.stlpeds.com) for the vaccines marked below.

Please call me at the following number _____ with any questions or concerns.

Please only mark the vaccine to be given today; this form will be invalid if all vaccines are marked.

Hepatitis B	**MMR**
DTaP	**Varicella**
Polio	**Tdap**
HiB	**Meningococcal**
Prevnar 13	**HPV**
Rotavirus	**Flu**
Hepatitis A	**Pneumovax 23 PPV**

Thank you,

_____

Parent Signature

Date: _____