Pediatric Vaccination Medical Authorization Release Form

For Child Insurance Policies

Child's Full Name

Date of Birth

Policy Number

Insurance Provider

Parent/Guardian Full Name

Relationship to Child

Contact Phone

Vaccinations Authorized

- [ ] Measles, Mumps, and Rubella (MMR)
- [ ] Polio
- [ ] DTaP (Diphtheria, Tetanus, Pertussis)
- [ ] Hepatitis B
- [ ] Varicella (Chickenpox)
- [ ] Hib (Haemophilus Influenzae type b)
- [ ] Other

Provider/Clinic Name

Provider/Clinic Address

Provider/Clinic Phone

I, the undersigned parent or legal guardian, hereby authorize the medical provider identified above to administer the selected vaccinations to my child named above. I authorize the release of relevant vaccination and medical records to the insurance provider for policy administration and claims processing. I attest that I have the legal authority to consent to medical treatment for this child.

Parent/Guardian Signature

_____

Date

_____