

**CATALINA PEDIATRICS**

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www.catalinapediatrics.com

I, \_\_\_\_\_, guardian/parent of \_\_\_\_\_, DOB: \_\_\_\_\_

Give my consent for treatment and vaccine administration as recommended by any of the physicians at Catalina Pediatrics, P.C.

Written VIS and vaccine counseling will be provided with each vaccination.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Person Signing

\_\_\_\_\_  
Relationship to Patient