Vaccine Waiver

Patient Name: _____ DOB: _____

VACCINE CONSENT: I have been given a copy of, and read, or have had explained to me information about each of the diseases and vaccines listed. I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited and ask that the vaccines listed be given to the minor named herein for who I am authorized to make this request.
FINANCIAL WAIVER: I understand that my health care insurance benefits may not cover the cost of the services provided or recommended by my physician. In the event that my insurance company declines to reimburse Fairfax Pediatric Associates, P.C., for non-covered services, I agree to assume full financial responsibility for any portion not covered.

○ DTap	$65.00
○ Hib	$55.00
○ IPV (Poliomyelitis)	$65.00
○ Pentacel (IPV, DTap, Hib)	$210.00
○ Pneumococcal	$325.00
○ Pneumovax-23	$156.00
○ Rotavirus	$175.00
○ Hepatitis-B	$56.00
○ MMR	$132.00
○ Varicella	$250.00
○ Hepatitis-A	$72.00
○ TDaP	$79.00
○ Meningococcal	$260.00
○ Gardasil 9 (HPV-9)	$400.00
○ Flu	$50.00
○ dT (under 7 years old)	$95.00
○ Td (7 years & older)	$55.00
○ Typhoid	$175.00
○ Trumenba (Meningococcal-B)	$425.00
○ Yellow Fever	$300.00
○ PPD Test	$33.00
○ Quadracel (IPV & DTap)	$80.00
○ ProQuad (MMR & Varicella)	$350.00

Parent / Guardian Name & Signature Date