Sparks Pediatric and Adolescent Medicine
975 Roberta Lane Suite 101B
Sparks NV 89431-1894
Office (775) 359-7111 FAX (775) 359-7114

Today's Date_____

First Name: _____ Middle init. ____ Last Name_____

Social Security #___/____/_____ D.O.B._____ Sex: M/F

Address _____

Street_____ City_____ State NV Zip Code_____

Telephone Number ( ) _____

Vaccines Requested (circle all that apply)

H1N1(swine flu)

Gardasil (Cervical Cancer)

Varicella (Chickenpox)

Tdap (whooping cough/tetanus)

MMR (Measles Mumps Rubella)

By signing below, I authorize Dr. Kevin Windisch and his staff to provide vaccination to me. I understand that this vaccination will not be billed to my insurance company and no insurance repricing will be accepted. By signing below I understand that I am fully responsible for the cost of this service. By signing below I further indicate that I am aware that the provision of these vaccines do not constitute a medical exam, nor does it establish me as a patient of Dr. Windisch or Sparks Pediatric and Adolescent Medicine. Consequently, Dr. Windisch will not be responsible for illnesses not related to the administration of this vaccine.

_____ _____

Patient's Signature Date