# Elective and Travel Vaccine Authorization Form

As a courtesy to our patients, South East Bay Pediatric Medical Group provides elective and/or travel vaccines that may **NOT** be covered by some insurance plans.

The vaccine(s) I am requesting for my child is/are:

_____

_____

_____

By signing below, I agree to be responsible for the full cost of the elective or travel vaccines given, and for any administration fees charged today. I understand that South East Bay Pediatric Medical Group will bill my insurance company for the above vaccine(s). I understand that I will be reimbursed in full by South East Bay Pediatrics only if payment is received from my insurance company.

Patient's Name: _____ Date: _____

Parent's Signature: _____

Parent's Name: _____