VACCINATION AGREEMENT

I understand that I must vaccinate my child according to the schedule required by Aquidneck pediatrics, LLC as we follow CDC and AAP guidelines unless a medical condition requires otherwise. I understand that my child will receive vaccines according to the required schedule which is in accordance with the recommendations of the American Academy of Pediatrics and the Centers for Disease Control and Prevention unless a medical condition requires early or delayed vaccination. I understand that this is a private practice and the providers can choose to deny care to my child if I do not follow the required schedule.

If my child is new to the practice, I agree to continue vaccinating according to the CDC schedule or according to the recommended catch-up schedule appropriate for my child's age. The providers at Aquidneck Pediatrics, LLC. may be willing to adjust the required schedule provided that each vaccine is given within the age range recommended by the CDC and all children are fully vaccinated within the time frame outlined by my provider. The providers at Aquidneck Pediatrics, LLC. reserve the right to approve or deny alterations to the required vaccine schedule. I understand that I am responsible for any additional fees associated with an alternate vaccination schedule.

I understand that if I choose to not vaccinate my child at all or choose to completely eliminate any vaccine from the schedule, my provider can refuse to provide services to my child. I understand that a detailed vaccination policy is available for my review. I also understand that there are vaccine information statements on file in the office for patient education, and I have the right to request and obtain said documents if I so desire.

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: ____ /____ /____

Patient's Name: _____ Date: ____ /____ /____