CONSENT TO IMMUNIZE

Please review and sign/initial below:

We are a pro-vaccine office. These vaccines listed below are **required** by our office:

-Dtap/Tdap
    -Diphtheria, Tetanus, and Pertussis
-Hepatitis B
-Hepatitis A
-Haemophilus influenzae
-Pneumococcal
-Polio
-Measles, Mumps, Rubella
-Varicella
-Rotavirus
-Meningitis Vaccines
    -MenB and MCV4 vaccine

Please initial here _____; agreeing to above vaccinations

If your child did not receive Hepatitis B vaccine in the newborn period (between birth and 1 month well visit) we are requiring them to have their first dose at their 2 month well child visit

If you are interested in an alternative vaccine schedule, which we do not endorse, vaccines can not be delayed more than 8 weeks. (Receiving 2 month vaccines no later than 4 months of age)

These vaccines are **recommended** but you may decline the following and remain patients at PCOL:
-HPV
-Seasonal Flu
-Seasonal COVID
-RSV (for those 9 mos and younger)

Please initial here _____; understanding the above vaccinations are recommended

Please understand by declining these vaccines you are accepting the risk for your child to have these illnesses.

Child's Name:
Parents Name:

Parent Signature: _____
Date: