jacobsonpediatrics

Robyn W. Jacobson M.D. & Rose James M.D.

IMMUNIZATION CONTRACT

By signing below, I am agreeing to give: _____ _____

(Patient's Name) (DOB)

ALL required childhood immunization and follow the recommended immunization schedule as follows:

- Newborn: Hepatitis B vaccine (#1)
- 2 Months- Pentacel , Vaxneuvance, Rota virus, Hepatitis B vaccine (#2)
- 4 Months- Pentacel , Vaxneuvance, Rota virus
- 6 Months- Pentacel , Vaxneuvance, Rota virus, Flu vaccine (if in season)
- 9 Months- Hepatitis B (#3), Hemoglobin levels checked for anemia
- 12 Months- MMR, VZV, Hepatitis A (#1)
- 15 months – Pentacel, Vaxneuvance
- 18 Months- 2 Years old - Hepatitis A (#2)
- 4-5 years – DTAP, Polio, MMR, VZV
- 11 Years and Older – Tdap, Menquadfi, HPV
- 16 years and Older- Tdap, Menquadfi, Trumenba (Men-B #1)
- 17–18-year-old – Trumenba (Men-B #2)

If I choose not to follow the above immunization schedule, I understand that I will not be seen in the office today and will need to locate a new Physician for my child.

_____ _____

Parent/Guardian Signature Date