

# ALEXANDER PEDIATRICS, LLC

## **Immunization policy**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. It is the policy of this practice that all children be vaccinated and receive their immunizations at the appropriate ages and visits.
2. We recommend the immunization schedule set by the American Academy of Pediatrics (AAP).
3. Refusal to vaccinate can result in dismissal and no further services at this practice.

Per AAP recommendations, vaccination is one of the best ways parents can protect their children. If you would like more information about the vaccination schedule, please visit our website at [www.alexanderpediatrics.com](http://www.alexanderpediatrics.com) or ask a staff member for a copy.

By signing below, I agree to follow the policy outlined by *Alexander Pediatrics, LLC*.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date