Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines
- We firmly believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the Center for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your healthcare provider prior to your visit. Please be advised that delaying or "breaking up vaccines'' to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers. Finally, if you should absolutely refuse to vaccinate your child despite our efforts (at his/her first visit) we will not be able to care for your child.**

As medical professionals, we feel strongly that vaccinating your children on schedule with current available vaccines is absolutely the right thing to do for all children and young adults. Thank You for your time in reading this policy and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

By signing below, I acknowledge that I have read and understand the above policy.

_____   _____

Patient Name (please print)   Date of Birth

_____

Parent/Guardian Signature:

Relationship to Patient (please check): ____Parent ____Self ____Other: _____