Royal
KIDS
Pediatric Clinic

ROYALKIDS CLINIC VACCINE POLICY

Like most pediatricians across the nation, providers at ROYALKIDS CLINIC are faced with the dilemma of protecting our patients and community from vaccine preventable illnesses while respecting the personal and religious beliefs of our individual families.

At ROYALKIDS CLINIC we recommend and follow the AAP (American Academy of Pediatrics) and ACIP (Advisory Committee on Immunization Practices) vaccination schedule. However, if a parent requests an alternative schedule, we do our best to work individually with the parent while optimizing the health of the patient and community. We firmly believe that delaying or 'breaking up the vaccines' (to give one or two at a time, over two or more visits) goes against expert recommendations and against our medical advice at ROYALKIDS CLINIC.Please realize that you will be required to sign a 'Refusal to Vaccinate' acknowledgement in the event of lengthy delays. All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age, all AAP-recommended immunizations by two years of age, and meningococcal vaccine, Tdap, booster doses of MMR and varicella vaccines by age 12 years.

The American Academy of Pediatrics says doctors should bring up the importance of vaccinations during visits but should respect a parent's wishes unless there's a significant risk to the child.
"In general, pediatricians should avoid discharging patients from their practices solely because a parent refuses to immunize his or her child," according to guidelines issued by the group.

However, if the relationship between patient and doctor becomes unworkable, or if you should absolutely refuse to vaccinate your child despite all our efforts, the pediatrics academy says, the doctor may want to encourage the vaccine refuser to go to another physician/health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician.

I acknowledge that I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE VACCINE POLICY Please Initial ____
Patient/Legal Representative (Print Name):_____
Patient/Legal Representative Signature: _____
Date: _____Time:_____AM/PM
Witness: _____ Date:_____Time: _____AM/PM