Trestlewood Pediatrics, PC

Immunization Contract

I (print) _____, agree to immunize

My Child (print) _____, in accordance with the

ACIP immunization schedule recommended by the pediatricians at Trestlewood Pediatrics.

Parent Signature _____ Date _____

Immunization Schedule

Birth/First Visit

Hep B

2 Month Visit

Pediarix (DTaP, IPV, Hep B)

Prevnar 13, Rotavirus, Hib

4 Month Visit

Pediarix (DTaP, IPV, HepB)

Prevnar 13, Rotavirus, Hib

6 Month Visit

Pediarix (DTaP, IPV, Hep B)

Prevnar 13, Rotavirus

9 Month Visit

N/A

12 Month Visit

MMR

Varicella, Hep A

15 Month Visit

DTaP, Prevnar 13, Hib

18 Month Visit

Hep A

2 Year

N/A

4 Year

DTaP/IPV

MMR/Varicella

11 Year

Tdap, Menactra,

HPV

12 Year

HPV

16 Year

Menactra

17/18 Year

MenB

18+ Year

MenB

***Flu vaccine advised annually.

***Make up vaccines as needed.

Updated 5/7/19