Robert B. Page, M.D., F.A.A.P.
Stephanie Somers, M.D., F.A.A.P.
Anthony J. Van Es, M.D., F.A.A.P.
Rebekah Lampart, M.D., F.A.A.P.

Immunization Contract

I (print name) ____, agree to immunize my child (print name) ____ in accordance with the ACIP immunization schedule recommended by the pediatricians at Trestlewood Pediatrics.

____ ______________________

Parent Signature Date

Immunization Schedule

Birth/First Visit
Hep B #1

2-Month Visit
Pediarix (DTaP, IPV, Hep B)
Prevnar 13, Rotavirus, Hib

4-Month Visit
Pediarix (DTaP, IPV, Hep B)
Prevnar 13, Rotavirus, Hib

6-Month Visit
Pediarix (DTaP, IPV, Hep B)
Prevnar 13, Rotavirus

9-Month Visit
Vaccines if needed

12-Month Visit
MMR, Varicella, Hep A

15-Month Visit
DTaP, Prevnar 13, Hib

18-Month Visit
Vaccines if needed

2-Year Visit
Hep A #2

2 ½-Year Visit
Vaccines if needed

3-Year Visit
Vaccines if needed

4-Year Visit
DTaP, IPV Polio
MMR, Varicella

5-Year Visit
4-year vaccines if not given

6-Year Visit
Vaccines if needed

7-Year Visit
Vaccines if needed

8-Year Visit
Vaccines if needed

9-Year Visit
Vaccines if needed

10-Year Visit
Vaccines if needed

11-Year Visit
Tdap, Menactra,
Start HPV Service

12-Year Visit
Vaccines if needed

13-Year Visit
Vaccines if needed
Complete HPV Service

14-Year Visit
Vaccines if needed

15-Year Visit
Vaccines if needed

16-Year Visit
Vaccines if needed

17-Year Visit
Menactra Booster (if needed)

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