

Patient Name _____

DOB: _____

VACCINES ▼	AGE▶	Birth	1mo	2mo	4mo	6mo	9mo	12mo	15mo	18-24mo	4-6 yrs
Alternate Schedule											
DTaP / PENTACEL / VAXELIS / QUADRACEL				DTaP (1)	DTaP (2)	DTaP (3)				DTaP (4)	DTaP (5)
	<i>Date Due</i>										
IPV / PENTACEL / VAXELIS / QUADRACEL				IPV (1)	IPV (2)	IPV (3)					IPV (4)
	<i>Date Due</i>										
HIB / PENTACEL / VAXELIS				HIB (1)	HIB (2)	HIB (3)				HIB (4)	
	<i>Date Due</i>										
HEP B (STARTING @ BIRTH) / VAXELIS		HEP B (1)		HEP B (2)	HEP B (3)	HEP B (4)					
HEP B (STARTING @ 2 mo) / VAXELIS				HEP B (1)	HEP B (2)	HEP B (3)					
	<i>Date Due</i>										
ROTATEQ (ORAL MED)				Rotateq (1)	Rotateq (2)	Rotateq (3)					
	<i>Date Due</i>										
PNEUMOCOCCAL / PCV-15				PCV-15 (1)	PCV-15 (2)	PCV-15 (3)			PCV-15 (4)		
	<i>Date Due</i>										
HEP A									HEP A (1)	HEP A (2)	
	<i>Date Due</i>										
MMR OR PROQUAD									MMR (1)		MMR (2)
	<i>Date Due</i>										
VARIVAX OR PROQUAD									Varivax (1)		Varivax (2)
	<i>Date Due</i>										

The above is an alternate immunization schedule that Child Care Consultants and you agree to comply with. If this agreement is not followed your child/children could be dismissed from our practice. This agreement follows our vaccine policy that was signed upon establishing your child with the practice.

Parent Signature _____ Date _____