Alpharetta Pediatrics

...where kids are special

Laura M. Bleekrode, M.D.

ALTERNATE VACCINE SCHEDULE AGREEMENT

Child's Name: _____ Date of Birth: _____

My health care provider has advised me of the recommended vaccines for my child. I have reviewed information explaining the vaccine(s) and the disease(s) they prevent. I have had the opportunity to discuss these topics with my child's health care provider, who has answered all of my questions regarding the vaccine(s). I understand the following:

- The purpose of and the need for the vaccine(s)
- The risks and benefits of the vaccine(s)
- If my child does not receive the vaccine there are consequences such as contracting the disease, transmitting the disease, and the inconvenience of remaining out of public settings if there is an outbreak of the disease.

Nevertheless, I have decided to follow an alternate vaccine schedule OR not to vaccinate at this time.

I agree to re-address this issue with my health care provider at each well care visit. I understand that I can change my mind and accept vaccination for my child in the future. If I have chosen to follow an alternate vaccine schedule, as discussed with my health care provider, I can return to the state recommended schedule at any time.

DATE	PARENT SIGNATURE	PHYSICIAN SIGNATURE

1100 Northmeadow Pkwy • Suite 108 • Roswell, Georgia 30076 • (770) 664-4430 • Fax (770) 664-7836
102 Pilgrim Village Dr. • Suite 300 • Cumming, Georgia 30040 • (678) 947-4588 • Fax (678) 947-3256