Crestwood Pediatric ASSOCIATES, PC

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ACCT#:_____

Vaccination Policy

(Please read and understand thoroughly)

We firmly believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the Centers for Disease Control and endorsed by the American Academy of Pediatrics. We believe in their safety and effectiveness and do not believe they are in any way related to autism. It is our desire to protect our community and the children in our waiting room from vaccine preventable diseases. We do not support delaying or spacing out of vaccinations. This puts our children at unnecessary risk and is not supported by any of the evidence based peer reviewed medical studies. Therefore, we would like to inform the parents and guardians of our patients that if you plan to delay or decline routine childhood vaccinations due to religious or other philosophical reasons, we will ask you to choose another healthcare provider that shares your views.

I understand that under state law (Virginia Code Section 32.1-45.1), health care providers are authorized to test patients for HIV antibodies or Hepatitis B and C whenever the health care provider or any person employed or under the direction or control of a health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus or HIV (which causes Aids), or Hepatitis B or C virus. According to this law, I understand that I will be deemed to have consented to such testing of my child, and to have consented to the release of the test results to the health care provider or other person who may have been exposed. Positive test results will also be disclosed to me as medically necessary, as otherwise required for me to seek treatment, and as required or permitted by law.

I understand that records including immunizations of a minor child will be maintained until the child reaches the age of 18, with a minimum time for record retention of six years from the last patient encounter regardless of age. The exception to this policy will be when the records are transferred to another physician, or provided to the patient, (parent/guardian).

I certify that I have read both pages of this form or had it read to me before I signed this agreement, and that I understand its content and significance. I further certify that I was provided an opportunity to ask questions regarding the content of this form, and those questions, if any, have been answered to my satisfaction.

_____	_____	_____
Signature of Parent/Legal Guardian	**Witness Signature**	**Date**