



Office Policies for Well Visit and Vaccinations Acknowledgment and Consent Form

Patient Name: _____

Date of Birth: _____ Date: _____

Dear Patient/Guardian,

Although science and medicine have proven that vaccines are safe and one of the greatest public health achievements of our time, we believe that no child should ever be turned away from quality healthcare. At Village Pediatrics, our primary goal is to ensure the health and well-being of all our patients.

To maintain a comprehensive approach to your child's health, we require that all patients, regardless of vaccination status, adhere to our well-child visit schedule.

Our well-child exam schedule:

• Newborn	• 1 Month	• 2 Month
• 4 Month	• 6 Month	• 9 Month
• 12 Month	• 15 Month	• 18 Month
• 2 Year	• 2.5 Year	• 3 + yearly*

**We see patients up to 21 years of age*

These visits are essential for:

- Monitoring growth and development
- Conducting age-appropriate screenings
- Providing anticipatory guidance
- Addressing any health concerns

Additionally, in compliance with Village Pediatrics office policies and regulations, we require that parents or guardians who choose not to vaccinate their children complete the necessary vaccine refusal documentation. This includes:

- Vaccine Refusal Documentation: Completion of a Refusal to Consent to Vaccination form, which will be included in your child's medical record. This form documents your decision and is required for our practice's records.

When your child is approaching school enrollment, which often requires a Nonmedical Immunization Waiver, You will need to refer to the instructions below-

- Nonmedical Immunization Wavier: A certified State of Michigan nonmedical Waiver form, which must be obtained from your local health department. This form requires you to receive education regarding the benefits of vaccination and the risks of disease before it can be signed and witnessed by a local health officer.

Please be aware the refusal to complete the recommended well-child visits and/or failure to sign the necessary immunization documentation will result in dismissal from our practice.

By signing below, I acknowledge that I have read and understood the above. I have had the opportunity to ask questions and all questions have been answered to my satisfaction.

Patient/Legal Guardian Signature: _____ Date: _____

(FOR OFFICE USE ONLY)

Provider Signature: _____ Date: _____