

## **Pediatric Services of Springfield Vaccination Policy**

At Pediatric Services of Springfield, we provide safe, evidence-based care for all children. Immunizations are a vital part of preventive pediatric healthcare and help protect individual patients and our broader community, including newborns, infants, and immunocompromised individuals.

Please review this policy carefully. We are happy to discuss any questions prior to establishing care.

### **Our Policy**

- Our practice follows the American Academy of Pediatrics (AAP) recommended immunization schedule.
- All patients are required to receive routine childhood vaccinations according to this schedule.
- Families who delay, selectively vaccinate, or decline vaccinations are not compatible with our practice model.
- No non-medical exemptions are accepted.
- Medical exemptions are granted only when clinically indicated and must be determined by the patient's healthcare provider.
- Continued care at our practice requires adherence to this vaccination policy.
- Families who choose to stop vaccinating, delay future vaccines or selectively vaccinate after establishing care will be required to transition to another pediatric provider.

### **Acknowledgment**

By signing below, I acknowledge that I have read and understand Pediatric Services of Springfield's Vaccination Policy and agree to comply with it. I understand that this practice requires patients to receive all routinely recommended childhood vaccinations per the AAP schedule unless a medical exemption is determined by the patient's healthcare provider. I understand that failure to comply with this policy while an active patient may result in dismissal from the practice, in accordance with applicable state regulations and notice requirements.

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Legal Guardian (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## NON-VACCINATED PATIENT PROTOCOL AGREEMENT

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_

### 1. Acknowledgment of Immunization Status

The undersigned acknowledges that the above-named patient is not immunized in accordance with the current immunization schedule recommended by the American Academy of Pediatrics (AAP) and adopted as the standard of care by this practice.

The Practice maintains immunization requirements in order to protect patients, families, and staff — including infants, pregnant patients, elderly individuals, and those who are medically vulnerable or immunocompromised — from preventable communicable diseases.

### 2. Condition of Continued Care

The undersigned understands and agrees that adherence to the following safety protocols is a mandatory condition of the Practice's agreement to continue providing medical services to the patient.

Patients must have a signed Refusal to Vaccinate form on file in order to continue receiving medical care from Pediatric Services of Springfield.

Failure to comply with any portion of this Agreement may result in termination of the provider-patient relationship, subject to applicable federal and Massachusetts laws, notice requirements, and continuity-of-care obligations.

### 3. Required Safety Protocols

#### A. Designated Site of Care

- Well-child visits will be available at both locations, while sick visits will only be offered at designated locations.
- The Practice reserves the right to modify scheduling locations as operational or safety considerations require.

#### B. Arrival and Entry Procedure

- The patient (or parent/guardian) must notify reception by telephone upon arrival and remain in their vehicle until instructed to enter.
- The patient must enter through the designated side entrance and proceed directly to the assigned examination room.
- Use of the waiting room is not permitted unless expressly authorized.

**C. Masking and Infection Control**

- The patient must wear a properly fitted mask covering nose and mouth at all times while inside the facility, and directed by the provider.
- All accompanying individuals must also wear masks at all times while inside the facility.
- The Practice reserves the right to require additional infection-control measures based on public health guidance or clinical judgment.

**D. Visit Completion**

- Upon conclusion of the visit, the patient and accompanying individuals shall exit through the designated side entrance.
- Billing matters, payments, and scheduling of follow-up appointments will be completed by telephone or through the patient portal when available.

**4. Internal Documentation**

The undersigned acknowledges that the patient’s immunization status will be documented and flagged within the Practice’s electronic medical record systems (including, but not limited to, Oracle SPM and PowerChart) solely for operational, scheduling, and safety-protocol purposes. Such documentation is maintained in accordance with HIPAA and applicable privacy regulations.

**5. No Waiver of Rights**

Nothing in this Agreement obligates the Practice to provide services beyond the scope of its policies, clinical judgment, or legal obligations. The Practice reserves the right to amend its policies in response to changes in public health guidance, regulatory requirements, or operational needs.

**6. Acknowledgment and Voluntary Agreement**

By signing below, the undersigned:

- Certifies that they have read and understand this Agreement in its entirety;
- Acknowledge that they have had the opportunity to ask questions;
- Agree to comply fully with all requirements set forth herein; and
- Understand that noncompliance may result in dismissal from the Practice consistent with applicable law.

Parent/Guardian Name (Printed): \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Patient Signature (if age 18 or older): \_\_\_\_\_