CHILD'S NAME: ______________________________ DOB: ______/______/________

H.I.P. IMMUNIZATION SCHEDULE

_____ We are following the **CDC schedule** for our child's immunizations.
_____ We are following the **Sears schedule** for our child's immunizations.
_____ We are following an **Alternative schedule** for our child's immunizations. *If selecting this option, please fill out the chart below and enter the age at which your child will receive the vaccine.*

Place an X next to the vaccines your child will receive	Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
	DTaP (5 doses)					
	Hepatitis A (2 doses)					
	Hepatitis B (3 doses)					
	Haemophilus Influenza Type B (4 doses)					
	Inactivated Polio Virus (4 doses)					
	MMR (2 doses)					
	Pneumococcal (4 doses)					
	Rotavirus (3 doses)					
	Varicella (2 doses)					

I understand that Highlands Integrative Pediatrics recommends the CDC's routine immunization schedule. I have reviewed this plan with my provider and understand that it is my responsibility to notify my provider *in writing* if there are any changes in this agreed upon plan.

Parent Signature: ______________________________ Parent Name: ______________________________ Date: _____________

Parent Signature: ______________________________ Parent Name: ______________________________ Date: _____________

Provider Signature: ______________________________ Provider Name: ______________________________ Date: _____________