BRIGHT OAKS
Pediatric Center

2111 Laurel Bush Rd. Ste H
Bel Air, MD 21015
(p) 410-569-3300 (f) 410-569-8199
www.BrightOaksPediatrics.com

Vaccination Policy

At Bright Oaks Pediatric Center, we strive to provide the best care that is based on the most up-to-date and accurate literature for our patients and families. In order to do this, we require all of our patients to receive immunizations on schedule, without spacing, delaying, alternate schedules, or otherwise.

Our vaccine schedule is available on our website as a clickable link titled:
“Immunizations and Exam Procedures you can expect at a Bright Oaks Well Visit”

While we respect one's choice to not vaccinate, we feel we would be doing a disservice to our patients and community, and feel uncomfortable as a practice caring for children who do not receive these recommended immunizations at all or whose families choose to go off schedule. The risk for errors and incomplete immunization increases any time there is deviation from the routine vaccination schedule.

Vaccines are a simple and easy way to prevent deadly illnesses and diseases. We ask that should you have questions or concerns regarding immunizations, ask your child’s healthcare provider. Unfortunately, there is a lot of misinformation on the internet, as anyone can publish or post an article. When researching, ensure you are looking at reputable and quality resources.

If a vaccine or vaccines have already been drawn up at your child’s scheduled appointment and are not administered at the visit, you will be responsible to pay for the full cost of the vaccine(s) as we are unable to bill insurance companies for vaccines not administered to a patient.

We look forward to caring for your child at Bright Oaks!

Please read the following statement and sign & date below to acknowledge your understanding:

I have read the Vaccination Policy and agree to abide by its terms.

I acknowledge that I will be given a copy to read or have explained to me the Vaccine Information Statement(s) about the vaccine(s) my child/I will receive, and the disease(s) they prevent.
I further acknowledge that upon receipt of the Vaccine Information Statement(s) I will have a chance to ask any questions and have them answered to my satisfaction, so that I may understand the risks of the vaccine(s) to be administered to my child/myself, for whom I am authorized to make this decision.

Patient Name: _____

Parent Signature: _____

Date: _____