

Patients Name/Paciente: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB/Fecha de Nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to follow the current guidelines and recommendations of the **American Academy of Pediatrics (AAP) and Centers for**

**Disease Control and Prevention (CDC).** This includes immunization scheduled requirements, treatments, and medical

recommendations. Failure to comply will result in dismissal from Pediatric Medical Group of Riverside, INC.

Accepto a las siguientes reglas y recomendaciones de acuerdo a **American Academy of Pediatrics (AAP) and Centers for**

**Disease Control and Prevention (CDC).** Esto incluye requerimientos de vacunas, tratamientos, y recomendaciones medicas.

Al no poder completer alguna de estas , estara despedido de la oficina de Pediatric Medical Group of Riverside, INC.

Print Name: (Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: (Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

American Academy of Pediatrics: [www.aap.org](http://www.aap.org)

Centers for Disease Control and Prevention (CDC) [www.cdc.gov](http://www.cdc.gov)