SOUTHSIDE PEDIATRICS IMMUNIZATION SCHEDULE

The following is a list of the Recommended/Required Childhood and Adolescent Immunizations.
Southside Pediatrics follows the AAP recommended Childhood and Adolescent Immunization Guidelines

Hepatitis B = HepB (**REQUIRED**)

Diphtheria, Tetanus, Pertussis,HepB,Poliovirus = Dtap (Pediarix) (**REQUIRED**)

Haemophilus Influenzae type B = Hib (**REQUIRED**)

Diphtheria,Tetanus, acellular pertussis + inactivated poliovirus - Dtap-IPV (Kenrix) **(REQUIRED)**

Varicella (chicken pox) (**REQUIRED**)

Pneumococcal = PCV *(**REQUIRED**)*

Diphtheria, Tetanus, Pertussis = Dtap (Infanrix) (**REQUIRED**)

Tetanus, diphtheria toxoids and acellular pertussis = Tdap (Boostrix) (**REQUIRED**)

Hepatitis A = HepA *(*recommended, not required*)

Rotavirus (RotaTeq Oral Vaccine) recommended, not required

Meningococcal - MCV4 **Booster #2 Recommended**

Human Papillomavirus = HPV (Gardasil) (*recommended, not required-- 3 Injection Series)

MMR = Measels, Mumps, Rubella   **(REQUIRED)**

Birth - 1 Month	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4 Years	11 to 12 Years	16 years 18 years
Hep B #1	Pediarix	Pediarix	Pediarix					Tdap	
							Kinrix		
	DTaP #1	DTaP #2	DTaP #3		DTaP #4		DTaP #5	MCV4#1	MCV4#2
	Hep B #2	Hep B #3	Hep B #4	*Hep A #1		*Hep A #2	IPV #4		
	IPV #1	IPV #2	IPV #3						
								*HPV#1	
	Hib #1	Hib #2		Hib #3					
	PCV #1	PCV #2	PCV #3	- MMR #1	PCV #4		MMR #2		
				Varicella #1			Varicella #2		
	*RotaVirus #1 (Oral)	*RotaVirus #2 (Oral)	*RotaVirus #3 (Oral)						

You should contact your insurance company prior to your 2 month immunizations. Ask about your preventative care coverage: Ask if there are any coverage limitations. What is subject to deductible? What is subject to co-pay? Be specific, some immunizations may not be covered. If after speaking to your insurance carrier, if you still have questions, please feel free to call the office. We can offer assistance, but can not guarantee coverage.