Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

OUR PROVIDERS

Dr. Leymaster: Graduated from the University of Cincinnati College of Medicine and completed his residency in pediatrics at Case Western Reserve University/Metro Health Medical Center in Cleveland in June 2002. Dr. Leymaster enjoys all areas of pediatrics and has a special interest in sports medicine. He is board certified and a Fellow in the American Academy of Pediatrics (F.A.A.P.) He joined our practice in July 2002. He was Chief of Pediatrics for Mt. Carmel St. Ann's Hospital from 2006-2012. He is a Clinical Assistant Professor of Pediatrics for Ohio University and a Clinical Preceptor for Ohio State University.

Dr. Yaw: Her pediatric training was completed at Wright State University School of Medicine/The Children's Medical Center of Dayton in 1998. She was in private practice for 8 years in the Dayton area. She joined our staff in August 2006. Dr. Yaw is board certified and is a Fellow in the American Academy of Pediatrics (F.A.A.P.) She is an associate professor at Wright State University.

Amanda Jett, R.N., M.S., C.P.N.P.-PC: Completed her undergraduate studies at The Ohio State University in 2002 before returning for her nursing degree and Master of nursing in advanced practice, specializing in pediatrics. She is board certified and joined our practice in 2018.

IMMUNIZATION & SCREENINGS SCHEDULE

1 Week	Office Visit	Weight check (Breastfed babies)
2 Week	Office Visit	Weight check
1 Month	Office Visit	Hep B
2 Months	Office Visit	DTaP [Diphtheria, Pertussis, Tetanus], IPV, HIB, Pneumococcal, Rota
4 Months	Office Visit	DTaP, IPV, HIB, Pneumococcus, Rotavirus
6 Months	Office Visit	DTaP, IPV, HIB, Pneumococcus, Rotavirus
9 Months	Office Visit	Hep B
1 Year	Office Visit	Pneumococcal, Hep A, Lead screening, Hemoglobin
15 Months	Office Visit	MMR (Measles, Mumps, Rubella), Varicella
18 Months	Office Visit	DTaP, IPV, HIB, Hep A, Developmental screening (M-Chat)
2 Years	Office Visit	Hep A (if not given at 18 months), Lead screening, TB screening
2 ½ Years	Office Visit	Developmental screening (M-Chat)
3 Years	Office Visit	Vision screening
4 Years	Office Visit	Vision & Hearing screening
5 Years	Office Visit	DTaP, IPV, MMR, Varicella (Chicken Pox), Vision & Hearing screening
9 – 11 Years	Office Visit	Lipid Screening (1 time between 9 & 11)
12 Years & older	Office Visit	Completion of HPV series and Meningococcal booster after 16 Years, Lipid screening once between ages 17-21

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Westerville Pediatric Specialists' Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox…I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."*

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under immunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

Furthermore, those that do not vaccinate their children take selfish advantage of thousands of others who do, which decreases the likelihood that their children will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Westerville Pediatric Specialists.** Such additional visits will require additional co-pays on your part.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

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HEALTH HISTORY

Child's Name _____ Date of Birth _____

Drug Allergies _____

Current Medications Dosage Times/Day

_____

_____

SOCIAL HISTORY - Child lives with (circle all that apply): Both Parents Mom Dad Step Mom Step Dad Adoptive Parents Foster Family Maternal Grandparents Paternal Grandparents Guardian Other (specify)_____

BIRTH HISTORY - Term or Preterm (<37 weeks): _____ Delivery Type: __vaginal __c-section

Complications regarding delivery/shortly after birth: _____

_____

PAST MEDICAL HISTORY - Overnight Hospitalization **(provide year and illness/operation)** _____

_____

Has your child ever had the following (circle yes or no, leave blank if uncertain):

ADD/ADHD	Y	N	Diabetes	Y	N	Mental Illness	Y	N
AIDS/HIV	Y	N	Gastroesophageal Reflux	Y	N	Menstrual Abnormalities	Y	N
Anemia	Y	N	Genetic Disease	Y	N	Tuberculosis	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Pneumonia	Y	N
Allergies	Y	N	Headaches	Y	N	Rheumatic Fever	Y	N
Apnea	Y	N	Hypertension	Y	N	Seizure Disorder	Y	N
Bladder Infections	Y	N	Intellectually Challenged	Y	N	Sleep Disturbance	Y	N
Bleeding Tendency	Y	N	Intestinal Disease	Y	N	STD	Y	N
Bone or Joint Disease	Y	N	Jaundice	Y	N	Thyroid Disease	Y	N
Bronchitis	Y	N	Kidney Disease	Y	N	Transfusions	Y	N
Bronchiolitis	Y	N	Learning Disability	Y	N	Ulcer	Y	N
Cancer	Y	N	Liver Disease	Y	N	Whooping Cough	Y	N
Cerebral Palsy	Y	N	**ADDITIONAL INFORMATION:**					
Chicken Pox	Y	N						
Constipation	Y	N						
Developmental delay	Y	N						

HEALTH HISTORY – page 2

Child's Name _____ Date of Birth _____

FAMILY MEDICAL HISTORY – This includes the child here today, parents, brothers and sisters.

	Relative	Explain
Alcohol-drug abuse		
Allergies (hay fever, asthma)		
Anemia (low blood, blood disease, sickle cell)		
Bone or joint disease (arthritis)		
Congenital anomalies (birth defects)		
Cystic fibrosis		
Heart Disease or Stroke (before age 50, high cholesterol)		
Hypertension (high blood pressure)		
Inborn errors of metabolism (PKU, thyroid)		
Infectious disease including TB		
Intellectually Challenged		
Intestinal disease (ulcer, ulcerative colitis, Crohn's Disease)		
Juvenile diabetes (onset prior to 18 years of age)		
Kidney disease including urinary tract infection		
Seizures		
Other		

_____ **NO SIGNIFICANT MEDICAL HISTORY**

Signature of Parent/Legal Guardian: _____Date_____

Office Use Only

Reviewed by:

_____

Physician/Nurse Practitioner Signature ***Date***

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Parent/Guardian Name: _____ M.I._____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Date of Birth: _____ SSN: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Parent/Guardian Name: _____ M.I._____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Date of Birth: _____ SSN: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

WPS has permission to leave messages regarding my child's health. **(check one) Brief message ____ Detailed message ____**

Signature_____ **(check one) Cell _____ Home ____ Work ____**

PHARMACY Name, Address & Phone Number: _____

I give permission for my medical provider to access pharmacy information from the pharmaceutical clearing house: **Yes ___ No ___**

CHILDREN:	**Please circle:**	**Date of Birth**
1) _____		
Child Name	***M/F***	***Date of Birth***
2) _____		
Child Name	***M/F***	***Date of Birth***
3) _____		
Child Name	***M/F***	***Date of Birth***
4) _____		
Child Name	***M/F***	***Date of Birth***

To assist in meeting Meaningful Use measures by the U.S. Government, please answer the following regarding your children:

Race: (circle one)	American Indian or Alaskan	Black or African American	White
	Asian	Native Hawaiian or Other	Decline
Ethnicity: (circle one)	Hispanic or Latino	Non-Hispanic or Latino	Decline
Primary Language: (circle one)	English	Hearing Impaired	Other _____

INSURANCE INFORMATION (Please present insurance card upon check-in)

1) Name of Insurance Company: _____ 2) Name of Insurance Company: _____

Name of who carries the insurance: _____ Name of who carries the insurance: _____

SSN: _____ Relationship to Patient: _____ SSN: _____ Relationship to Patient: _____

Assignment and Release

Payment and/or copayment is required at the time the service is rendered. I hereby authorize my insurance benefits to be paid directly to the physician, and I authorize the physician to release any information required to process any claims. I acknowledge that I am financially responsible for any non-covered services. By my signature, I authorize the release of immunization records, daycare forms, and medical records to another healthcare provider or daycare/school.

Signature: _____ **Printed Name:** _____ **Date:** _____

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AUTHORIZATION TO SEEK MEDICAL CARE

Note: It is <u>NOT</u> necessary to list parents/legal guardians on this form.

Patient(s) name(s): _____

_____

The individuals named below and their relationship to the patient(s) are authorized to schedule appointments and seek care **<u>for illness or injury</u>** for the above-named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. *Please be advised the individuals named below are people who will have access and knowledge of private health information.*

1) _____
Relationship

2) _____
Relationship

3) _____
Relationship

4) _____
Relationship

Please note: We understand that grandparents, babysitters, or others may render care for your children. However, if the Westerville Pediatric Specialists, Inc. visit is for a routine well-care visit, it is our policy not to perform such services <u>unless a parent or legal guardian is present</u>. **Additionally, immunizations must be authorized by the parent or legal guardian by federal law.**

---------<u>DO NOT COMPLETE BELOW PORTION UNTIL IN THE PRESENCE OF A NOTARY</u>---------

I _____, parent/legal guardian of the above-named patient(s) give
Parent/Legal Guardian (printed)

permission for the above-named authorized individuals to seek medical care in my absence.

_____ _____
Parent/Legal Guardian Signature ***Date***

Notary: _____ **Witness:** _____

County: _____ **State:** _____ **Expires:** _____