

Refusal to Vaccinate

Patient Name: _____ Patient ID# _____

My doctor/nurse, _____ has advised me that I (named above) should receive the following vaccines:

Recommended	Declined
<input type="checkbox"/> Hepatitis B vaccine	<input type="checkbox"/>
<input type="checkbox"/> Diphtheria, tetanus, acellular pertussis (DTaP or Tdap) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Diphtheria tetanus (DT or Td) vaccine	<input type="checkbox"/>
<input type="checkbox"/> <i>Haemophilus influenzae</i> type b (Hib) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Pneumococcal conjugate or polysaccharide vaccine	<input type="checkbox"/>
<input type="checkbox"/> Inactivated poliovirus (IPV) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Measles-mumps-rubella (MMR) vaccine.	<input type="checkbox"/>
<input type="checkbox"/> Varicella (chickenpox) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Influenza (flu) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Meningococcal conjugate or polysaccharide vaccine	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis A vaccine	<input type="checkbox"/>
<input type="checkbox"/> Rotavirus vaccine	<input type="checkbox"/>
<input type="checkbox"/> Human papillomavirus vaccine	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>

I have read the Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine(s) and the disease(s) it prevents. I have had the opportunity to discuss this with my doctor or nurse, who has answered all of my questions regarding the recommended vaccine(s). I understand the following:

- The **purpose** of and the need for the recommended vaccine(s).
- The **risks and benefits** of the recommended vaccine(s).
- If I do not receive the vaccine(s) according to the medically accepted schedule, **the consequences** may include:
 - Contracting the illness the vaccine should prevent (The outcomes of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, paralysis, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well).
 - Transmitting the disease to others.
- My doctor or nurse, the American Academy of Family Physicians and the Centers for Disease Control and Prevention all strongly recommend that the vaccine(s) be given according to recommendations.

Nevertheless, I have decided at this time to decline or defer the vaccine(s) recommended, as indicated above, by checking the appropriate box under the column titled "Declined."

I know that failure to follow the recommendations about vaccination may endanger my health or life and others with which I might come into contact.

I know that I may readdress this issue with my doctor or nurse at any time and that I may change my mind and accept vaccination anytime in the future.

I acknowledge that I have read this document in its entirety and fully understand it.

Signature _____

Date _____

Witness _____

Date _____