



## Refusal to Vaccinate

This document must be completed before a provider can sign a Certificate of Exemption from school, childcare and preschool immunization requirements. Your provider may also request this in other situations. A copy will be provided on request.

Name of Child: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**My child's doctor/nurse has advised me that my child (named above) should receive the following vaccines:**

Recommended	Declined	Name of Vaccine
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hep B</b> – Hepatitis B vaccine
<input type="checkbox"/>	<input type="checkbox"/>	<b>DTaP or Tdap</b> – Diphtheria tetanus, acellular pertussis vaccine
<input type="checkbox"/>	<input type="checkbox"/>	<b>DT or Td</b> – Diphtheria tetanus vaccine
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hib</b> – Haemophilus influenzae type b
<input type="checkbox"/>	<input type="checkbox"/>	<b>PCV</b> – Pneumococcal conjugate or polysaccharide vaccine
<input type="checkbox"/>	<input type="checkbox"/>	<b>IPV</b> – Inactivated poliovirus vaccine
<input type="checkbox"/>	<input type="checkbox"/>	<b>MMR</b> – Measles-mumps-rubella vaccine
<input type="checkbox"/>	<input type="checkbox"/>	<b>Varicella</b> – Chickenpox vaccine

I have read the Vaccine Information Statement from the Center 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 child's doctor or nurse, who has answered all my questions regarding the recommended vaccine(s). I understand the following:

- The **purpose** of and the need for the recommended vaccine(s)
- The **benefits and risks** of the recommended vaccine(s)
- If my child does not receive the vaccine(s) according to the medically accepted schedule, the **consequences** may include:

- o 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, deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well.
- o Transmitting the disease to others
- o Requiring my child to stay out of child care or school during disease outbreaks

My child's doctor or nurse, the American Academy of Pediatrics, the American Academy of Family Physicians and the Center of 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 for my child, as indicated above, by checking the appropriate box under the column titled "Declined".

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

I know that I may address this issue with my child's doctor or nurse at any time and that I may change my mind and accept vaccination for my child any time in the future.

With my signature, I acknowledge that I have read this document in its entirety, fully understand it, and accept responsibility and consequences to my child for my decision to decline the recommended vaccine(s).

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewing Physician or Nurse Practitioner \_\_\_\_\_ Date \_\_\_\_\_

Check here if Certificate of Exemption (COE) signed by provider after review of Refusal to Vaccinate form