

REFUSAL TO VACCINATE

Child's Name: _____

Parent's/Guardian's Name _____

My child's doctor/nurse has advised me that my child (named above) should receive the following vaccine(s) listed for my child by placing my initials behind the named vaccine(s) listed under "Declined Vaccine(s)".

Declined Vaccine(s)

Name of Vaccine(s)	Initials	Name of Vaccine(s)	Initials
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

I have read the Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the Vaccine 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 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 my child does not receive the vaccine(s) according to the medically accepted schedule, **the consequences** may include:
 - Contracting the illness the vaccine should prevent.
 - Transmitting the disease to others.
- My child's provider, the American Academy of Pediatrics, 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 and clearly support preventing disease through vaccination.

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

I know that I may readdress 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 at anytime in the future.

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

Parent/Guardian Signature: _____ Initials: _____ Date/Time: _____

Witness Signature: _____ Date/Time: _____

