

Refusal to Vaccinate

Child's Name _____ Child's ID# _____

Parent's/Guardian's Name _____

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

Recommended

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

Declined

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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 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 (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
 - 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 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 for my child, 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 the health or life of my child and others with whom 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 anytime in the future.

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

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

I have had the opportunity to rediscuss my decision not to vaccinate my child and still decline the recommended immunizations.

Parent's initials _____ Date _____ Parent's initials _____ Date _____

Parent's initials _____ Date _____ Parent's initials _____ Date _____

American Academy of Pediatrics

