



Refusal to Vaccinate

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

Patient Name: _____

Patient Date of Birth: _____

My child's provider, or my provider (if 18+), has advised that the patient (named above) should receive the following vaccines:

RECOMMENDED	DECLINED	NAME OF VACCINE
		Hep B – Hepatitis B vaccine
		DTaP or Tdap – Diphtheria tetanus, acellular pertussis vaccine
		Hib – Haemophilus influenzae type b
		IPV – Inactivated poliovirus vaccine
		PCV – Pneumococcal conjugate or polysaccharide vaccine
		MMR – Measles-mumps-rubella vaccine
		Varicella – Chickenpox vaccine
		COVID – COVID-19 vaccine

I have been offered the Vaccine Information Statement (VIS) from the Center for Disease Control and Prevention (CDC) explaining the vaccine(s) and the disease(s) it prevents. I have had the opportunity to discuss this with my child's provider, or my provider (if 18+), 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:
 - 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
 - Transmitting the disease to others
 - Requiring my child to stay out of child care or school during disease outbreaks
- My child's provider, or my provider (if 18+), 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, or myself (if 18+), 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, or myself (if 18+), and others with whom my child or myself might come into contact.

I know that I may address this issue with my child's provider, or my provider (if 18+), at any time and that I may change my mind and accept vaccination for my child, or myself (if 18+), 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 or myself for my decision to decline the recommended vaccine(s).

Signature of patient or parent/guardian if patient is under 18
By typing your name in the signature field, you confirm that the information provided above is accurate to the best of your knowledge.

Date

Reviewing Physician or Nurse Practitioner

Date

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