



# PediatriCare Associates

*Pediatric and Adolescent Medicine*

## REFUSAL TO VACCINATE

Child's Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

My child's health care provider, **PediatriCare Associates**, has advised me that my child (named above) should receive the following vaccines:

<u>Recommended</u>	<u>Vaccine(s)</u>	<u>Declined</u>	<u>Recommended</u>	<u>Vaccine(s)</u>	<u>Declined</u>
<input type="checkbox"/>	Diphtheria Tetanus Acellular Pertussis	<input type="checkbox"/>	<input type="checkbox"/>	Meningococcal	<input type="checkbox"/>
<input type="checkbox"/>	Haemophilus influenzae type B (HIB)	<input type="checkbox"/>	<input type="checkbox"/>	Pneumococcal Conjugate	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Polio Vaccine (IPV)	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Rotavirus	<input type="checkbox"/>
<input type="checkbox"/>	Human Papillomavirus (HPV)	<input type="checkbox"/>	<input type="checkbox"/>	Varicella (Chickepox)	<input type="checkbox"/>
<input type="checkbox"/>	Influenza (flu)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>
<input type="checkbox"/>	Measles, Mumps, Rubella (MMR)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Sheet(s) explaining the vaccine(s) and the disease(s) they prevent. I have had the opportunity to discuss these with my child's health care provider, 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), the consequences may include:
  - contracting the illness the vaccine should prevent.
  - transmitting the disease to others.
  - the need for my child to stay out of daycare or school during disease outbreaks.
  - serious illness and/or possible death.
- My health care provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the center for Disease Control and Prevention have all strongly recommend the vaccine(s) be given.

Nevertheless I have decided to decline 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/or others that my child might come in contact with.

I AM AWARE THAT IT IS MY RESPONSIBILITY TO INFORM ALL HEALTH CARE PROFESSIONALS, AT THE TIME OF ANY ILLNESS OR VISIT, THAT MY CHILD IS NOT FULLY IMMUNIZED.

I know that I may re-address this issue with my health care provider at anytime 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 and the risk to my child. I hereby release PediatriCare Associates of all responsibilities involved by not giving my child said immunizations.

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

Parent/Guardian Name: \_\_\_\_\_  
Please Print

Witnessed by: \_\_\_\_\_  
Signature date