Refusal of Recommended Immunizations

Child's Name ______________________ ID# ______________ DOB ______________

Parent's / Guardian's Name ______________________

My child's pediatrician or other health care provider, ______________, has advised me that my child (named above) should receive each vaccine or immunization checked below:

Recommended today, *which prevents these serious complications:*	**Today I refused:** *Initials of Parent or Guardian*
☐ **COVID-19 vaccine** *Pneumonia, respiratory failure, blood clots, bleeding disorder, injury to liver, heart or kidney, multi-system inflammatory syndrome, post-COVID syndrome, death*	
☐ **Diphtheria, tetanus, acellular pertussis (DTaP or Tdap) vaccine** *Tetanus – broken bones, breathing difficulty, death; Diphtheria – swelling of the heart muscle, heart failure, coma, paralysis, death; Pertussis(whooping cough) – pneumonia, death*	
☐ **Haemophilus *influenzae* type B (Hib) vaccine** *Meningitis, intellectual disability, closing of the throat, pneumonia, death*	
☐ **Hepatitis A (HepA) vaccine** *Liver failure, joint pain, kidney, pancreatic and blood disorders, death*	
☐ **Hepatitis B (HepB) vaccine** *Chronic liver infection, liver failure, liver cancer, death*	
☐ **Human papillomavirus (HPV) vaccine** *Cervical, vaginal, vulvar, penile, anal, mouth and throat cancers*	
☐ **Influenza (flu) vaccine** *Pneumonia, bronchitis, sinus infections, ear infections, death*	
☐ **Measles, mumps, and rubella (MMR) vaccine** *Measles - brain swelling, pneumonia, death; Mumps - meningitis, brain swelling, swelling of testicles or ovaries, deafness, death; Rubella – miscarriage, stillbirth, premature delivery, birth defects*	
☐ **Meningococcal (circle: MenACWY / MenB / MenABCWY) vaccine** *Meningitis, infection of the bloodstream, blindness, deafness, loss of limbs, death*	
☐ **Pneumococcal (PCV) vaccine** *Blood infection, meningitis, death*	
☐ **Poliovirus (IPV) vaccine (inactivated)** *Paralysis, death*	
☐ **Respiratory syncytial virus (RSV) immunization** *Bronchiolitis, pneumonia, lung failure, death*	
☐ **Rotavirus (RV) vaccine** *Severe diarrhea, dehydration, death*	
☐ **Varicella Chickenpox (VAR) vaccine** *Infected blisters, bleeding disorders, brain swelling, pneumonia, death*	
☐ **Others (please list)** ______________________	

I have been given a Vaccine Information Statement from the Centers for Disease Control and Prevention that explains each immunization and the disease(s) it prevents. I have discussed the recommendation and my refusal with my child's pediatrician or other healthcare provider. They have answered all of my questions about the recommended immunizations. I know I can find more information at https://www.cdc.gov/vaccines/parents/FAQs.html.

I understand the following:

- The checked immunization(s) are recommended by my child's pediatrician or healthcare provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention.
- The benefits and risks of the recommended immunization(s) checked.
- If my child does not receive the immunization(s) according to the standard, evidence-based schedule, the consequences may include:
  - Contracting the illness the immunization is designed to prevent, which could lead to serious complications as listed in the table.
  - Transmitting the disease to others (including those too young to be vaccinated or those with immune problems), possibly requiring my child to stay out of child care or school and requiring someone to miss work to stay home with my child during disease outbreaks.
- Some immunization-preventable diseases are common in other countries. My unvaccinated child could get one of these diseases while traveling or from someone who traveled to another country.

Today, I refused the recommended immunization(s) for my child by initialing the box(es) in the column titled "Today I refused."

I agree to tell all health care professionals in all settings which immunization(s) my child has not received and if my child is under immunized, as my child may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been immunized.

If you change your mind at any time, speak with your child's pediatrician or other health care provider. You can always accept immunization(s) for your child in the future.

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

Parent / Guardian Signature: ______________________ Date: ______________

Pediatrician / Other Health Care Provider: ______________________ Date: ______________

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