REFUSAL TO VACCINATE

Client Name ______________________________ Client DOB ____________________

Parent/Guardian Name ____

Healthcare Provider's Name ______________________ Healthcare Provider's Address & Phone ______________________

My healthcare provider has advised that I / my child *(circle one)* should receive the following vaccines:

Recommended	Vaccinations	Declined
☐	Diphtheria, Tetanus, acellular Pertussis (**DTaP** or **Tdap**) Vaccine	☐
☐	Diphtheria Tetanus (**DT**) or Tetanus diphtheria (**Td**) Vaccine	☐
☐	*Haemophilus influenzae* type b (**Hib**) Vaccine	☐
☐	Hepatitis A Vaccine (**HAV**)	☐
☐	Hepatitis B Vaccine (**HBV**)	☐
☐	Human Papillomavirus Vaccine (**HPV**)	☐
☐	Inactivated Polio Virus Vaccine (**IPV**)	☐
☐	Influenza (**flu**) Vaccine	☐
☐	Measles-Mumps-Rubella (**MMR**) Vaccine	☐
☐	Meningococcal Vaccine (**MCV4**, **MenB**, **MPSV4**)	☐
☐	Pneumococcal Vaccine (**PCV** or **PPSV**)	☐
☐	Rotavirus Vaccine	☐
☐	Varicella (Chickenpox) Vaccine	☐
☐	Zoster Vaccine	☐
☐	Other _____	☐

I have read the Vaccine Information Statement(s) from the Centers for Disease Control and Prevention, which explain the vaccine(s) and the disease(s) they prevent. I have had the opportunity to discuss these with my healthcare 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 (I) my child (do) does not receive the vaccine(s), **the consequences** may include:
  - Contracting the illness the vaccine should prevent (The outcomes of these illnesses may include but are not limited to one or more of the following: hospitalization, pneumonia, brain damage, meningitis, seizures, deafness, and death.)
  - transmitting the disease to others (If an outbreak of vaccine-preventable disease occurs at my child's school or child care and my child is not protected, he/she may not be permitted to return until risk of catching the disease has passed.)
- My healthcare provider, the Georgia Immunization Program, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all strongly recommend that these vaccines be given according to the published Advisory Committee on Immunization Practices (ACIP) schedule. Nevertheless, I have decided at this time to decline the vaccine(s) recommended for me / my child, as indicated above, by checking the appropriate box under the column titled "declined."

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

I understand that I may discuss this issue with my (my child's) healthcare provider and that I may change my mind and accept vaccination for myself (my child) anytime in the future.

I understand that my refusal to have my child vaccinated does not exempt my child from Georgia school or child care facility immunization requirements and that he/she will be unable to attend school or child care without the required vaccinations.

Client/Parent/Guardian Signature ______________________________ Date ________________

Witness ______________________________ Date ________________