



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
<input type="checkbox"/>	Diphtheria, Tetanus, acellular Pertussis (DTaP or Tdap) Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	Diphtheria Tetanus (DT) or Tetanus diphtheria (Td) Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	<i>Haemophilus influenzae</i> type b (Hib) Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis A Vaccine (HAV)	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis B Vaccine (HBV)	<input type="checkbox"/>
<input type="checkbox"/>	Human Papillomavirus Vaccine (HPV)	<input type="checkbox"/>
<input type="checkbox"/>	Inactivated Polio Virus Vaccine (IPV)	<input type="checkbox"/>
<input type="checkbox"/>	Influenza (flu) Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	Measles-Mumps-Rubella (MMR) Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	Meningococcal Vaccine (MCV or MPV)	<input type="checkbox"/>
<input type="checkbox"/>	Pneumococcal Vaccine (PCV or PPSV)	<input type="checkbox"/>
<input type="checkbox"/>	Rotavirus Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	Varicella (Chickenpox) Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	Zoster Vaccine	<input type="checkbox"/>
<input type="checkbox"/>	Other	<input type="checkbox"/>

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 Office, 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 _____