Modified AAP Refusal of Vaccination Form

Child's Name _____ Child's ID#_____

Parent's/Guardian's Name(s)_____ _____

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

Vaccine	Recommended	Declined	Date
Hepatitis B	Y / N	Y / N	____/_____/____
DTaP	Y / N	Y / N	____/_____/____
DT or Td	Y / N	Y / N	____/_____/____
Haemophilus influenza type B (Hib)	Y / N	Y / N	____/_____/____
Pneumococcal conjugate vaccine	Y / N	Y / N	____/_____/____
Polio vaccine (IPV)	Y / N	Y / N	____/_____/____
Measles, mumps, rubella MMR-II	Y / N	Y / N	____/_____/____
Varicella (chickenpox)	Y / N	Y / N	____/_____/____
Influenza (flu)	Y / N	Y / N	____/_____/____
Meningococcal	Y / N	Y / N	____/_____/____
Hepatitis A	Y / N	Y / N	____/_____/____
Rotavirus	Y / N	Y / N	____/_____/____
Other_____	Y / N	Y / N	____/_____/____
Other_____	Y / N	Y / N	____/_____/____

I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Sheet(s) (VIS) explaining the vaccine(s) and the disease(s) for which each vaccine is intended. I have had the opportunity to discuss this with my child's health care provider, who has answered all of my questions regarding the recommended vaccine(s).

I understand the following:

● The intended purpose of the recommended vaccine(s)
● The known risks and alleged benefits of the recommended vaccine(s)
● If my child does receive the vaccine(s), the consequences may include:
-Contracting the illness the vaccine should have prevented.
- Transmitting the disease to others.
-Chronic illness and/or death.
-Suffering from any of the adverse events listed in the package insert and possibly adverse events not yet listed and/or associated with the vaccine. The outcomes of these adverse events may include one or more of the following: illness requiring hospitalization, death, brain damage, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccines are possible as well.
● If my child does not receive the recommended vaccines, possible adverse outcomes are the same as listed above for a child that does receive the vaccines.
● I understand the need to keep my child at home or in qualified care anytime the child exhibits symptoms of contagious diseases.
● My health care provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention have all strongly recommended that the vaccine(s) be given based on the *"information"* they have been given by the drug companies producing the vaccines.

I have declined consent for the vaccine(s) recommended for my child, as indicated above, by circling the appropriate mark under the column titled "Declined." I know that I may re-address this issue with my health care provider at any time, and that I may change my mind as personal beliefs are subject to evolve and change over time. I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature _____ _____
Date____/_____/____ Date____/_____/____

Witness_____ Date____/_____/____