

Town Pediatrics, PC

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REFUSAL TO VACCINATE

CHILD'S NAME _____

CHILD'S DOB _____

PARENT/GUARDIAN NAME _____

I have been provided with and given the opportunity to read each Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine(s) and the disease(s) it prevents for each of the vaccine(s) checked as recommended and which I have declined, as indicated on reverse side. I have had the opportunity to discuss the recommendation and my refusal with my child's doctor or nurse, who has answered all of my questions about the recommended vaccine(s). A list of reasons for vaccinating, possible health consequences of non-vaccination, and possible side effects of each vaccine is available at www.cdc.gov/vaccines/pubs/vis/default.htm. I understand the following:

- The purpose of and the need for the recommended vaccine(s).
- The risks and benefits of the recommended vaccine(s).
- That some vaccine-preventable diseases are common in other countries and that my unvaccinated child could easily get one of these diseases while traveling or from a traveler.
- If my child does not receive the vaccine(s) according to the medically accepted schedule, the consequences may include:
 - Contracting the illness the vaccine is designed to prevent (the outcomes of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, paralysis, meningitis, seizures, and deafness; other severe and permanent effects from these vaccine-preventable diseases are possible as well).
 - 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.

- My child's doctor and the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all strongly recommend that the vaccine(s) be given according to recommendations.

▪ That Virginia law imposes an obligation upon the parents or guardians of any minor child within the Commonwealth to cause such child to be immunized in accordance with the Immunization Schedule developed and published by the Virginia State Department of health, and that such obligation is subject only to limited exceptions.

- That, subject to limited exceptions, Virginia law imposes immunization requirements as a condition to admission to public school, and that failure to immunize my child may preclude school administrators from admitting my child.

Nevertheless, I have decided at this time to decline or defer 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 others with whom my child might come into contact. I therefore agree to tell all health care professionals in all settings what vaccines my child has not received because he or she may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been vaccinated.

I know that I may readdress this issue with my child's doctor or nurse at any time and that I may change my mind and accept vaccination for my child any time in the future.

I understand that my doctor, _____, and Town Pediatrics, PC assume no liability to me or to any third party for the medical, public health, legal, or educational consequences of my decision to decline or defer these vaccinations, and I acknowledge that I am solely responsible for my decision to decline or defer these vaccinations.

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

Parent/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____

I have had the opportunity to rediscuss my decision not to vaccinate my child and still decline the recommended immunizations

Parent's Initials: _____ Date: _____ Parent's Initials: _____ Date: _____

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My child's doctor/nurse, _____, has advised me that my child should receive the following vaccine(s):

Recommended	Declined
<input type="checkbox"/> Hepatitis B vaccine	<input type="checkbox"/>
<input type="checkbox"/> Diphtheria, tetanus, acellular pertussis (DTap or Tdap) vaccine	<input type="checkbox"/>
<input type="checkbox"/> <i>Haemophilus influenzae</i> type b (Hib) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Pneumococcal conjugate or polysaccharide vaccine	<input type="checkbox"/>
<input type="checkbox"/> Inactivated poliovirus (IPV) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Measles-mumps-rubella (MMR) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Varicella (chickenpox) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Meningococcal conjugate or polysaccharide vaccine	<input type="checkbox"/>
<input type="checkbox"/> Hepatitis A vaccine	<input type="checkbox"/>
<input type="checkbox"/> Rotavirus vaccine	<input type="checkbox"/>
<input type="checkbox"/> Human papillomavirus (HPV) vaccine	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>

PARENT/GUARDIAN NAME _____

PARENT/GUARDIAN SIGNATURE _____