

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66: the proponent agency is the Office of The Surgeon General.

REPORT TITLE

OTSG APPROVED (Date)

IMMUNIZATION CLINIC REFUSAL TO VACCINATE FORM

Child's Name: _____

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:

Recommended

Declined

- Diphtheria, Tetanus, acellular Pertussis (DTaP) vaccine
- Diphtheria, Tetanus (DT or dT) vaccine
- Heamophilus influenza type B (Hib) vaccine
- Hepatitis A vaccine
- Hepatitis B vaccine
- Influenza (flu) vaccine
- Measles, mump, Rubella (MMR) vaccine
- Meningococcal vaccine
- Pneumococcal conjugate vaccine (Prevnar)
- Polio vaccine (IPV)
- Other: _____

-
-
-
-
-
-
-
-
-
-
-

I have read the Center for Disease Control and Prevention's (CDC) Vaccine Information Sheet(s) explaining the vaccine(s) and the disease(s) they prevent. I have had the opportunity to discuss these with my child's health care provider, who has answered my questions regarding the recommended vaccine(s). I understand the following:

- The purpose of and need for the recommended vaccine(s)
- The risks and benefits of the recommended vaccine(s)
 - If my child does not receive the vaccine(s), the negative results could include:
 - Getting the illness the vaccine should prevent
 - Spreading the disease to others
- The need for my child to stay out of daycare/school during disease outbreaks
- My health care provider, the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) have all recommended that the vaccine(s) be given.

However, I have chosen to decline the vaccine(s) recommended for my child, as indicated above, by checking the appropriate box under the column titled "**Declined**".

I know that refusing to follow the recommendation about the vaccination may risk the health of my child and others that my child might come in contact with.

I know that I may discuss this issue with my health care provider at any time, and that I may change my mind and have my child vaccinated anytime in the future.

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

Sponsor's Signature _____

Witness's Signature _____

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, First, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL
- OTHER EXAMINATION OR EVALUATION
- DIAGNOSTIC STUDIES
- TREATMENT
- FLOW CHART
- OTHER (Specify)