I agree to tell all health care and all education professionals in all settings what vaccines I/my child have/has not received. Lacking immunization may require isolation or immediate medical evaluation and tests that might not be necessary if the vaccines had been given.

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

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

ADULT WORKER OR PARENT/GUARDIAN SIGNATURE DATE

WITNESS NAME (PRINT)

WITNESS SIGNATURE DATE

Adapted with permission from the American Academy of Pediatrics. Refusal to Vaccinate. Accessed Aug.29, 2013. 2019 posted version available at https://downloads.aap.org/DOPCSP/SOID_RTV_form_01-2019_English.pdf