Refusal to Consent to Child & Adolescent Immunization: Birth through 18 years

This is a tool for provider practices to use for documentation in the patient's medical record. **This is not an immunization waiver.** Contact your local health department for more information. Remember to document immunization refusal in the Michigan Care Improvement Registry (MCIR).

Name of Child: _____ Child's ID# or DOB: _____

Name of Parent/Guardian: _____

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

	Recommended Immunizations	Declined	Reason for Refusal
	COVID-19		
	Diphtheria/Tetanus/Pertussis: DTaP		
	Haemophilus influenzae type b: Hib		
	Hepatitis A: HepA		
	Hepatitis B: HepB		
	Human Papillomavirus: HPV		
	Influenza		
	Measles/Mumps/Rubella: MMR		
	Meningococcal Conjugate: MenACWY		
	Meningococcal B: MenB		
	Pentavalent Meningococcal: MenABCWY		
	Pneumococcal: PCV15, PCV20, PPSV23		
	Polio: IPV		
	Respiratory Syncytial Virus: RSV Vaccine (Abrysvo®)		
	Respiratory Syncytial Virus: Monoclonal Antibody (RSV-mAb)		
	Rotavirus: RV		
	Tetanus/diphtheria/pertussis: Tdap or Td		
	Varicella (Chickenpox): VAR		
	Other:		

I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement(s) explaining the immunization(s) and the disease(s) they prevent. My child's health care provider has explained to me, and I understand the following:

- The **purpose** of the recommended immunization(s).
- The **risks** of disease and the **benefits and potential risks** of the recommended immunization(s).
- The **responsibilities** of not being fully immunized.
- The **possible consequence(s)** of not allowing my child to receive the recommended immunization(s) may include contracting the illness the immunization is intended to prevent and spreading the disease to others.
- My child's health care provider, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists and the Michigan Department of Health and Human Services **strongly recommend** that the immunization(s) be given.

My child's health care provider has answered all my questions.
I know that I may change my mind and allow immunization for my child in the future.
I accept sole responsibility for any consequences that result from my child not being immunized.
I acknowledge that I have read this document in its entirety and fully understand it.

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date