

McLaren Print System Order

Order No: 50066 Reprint Previous Order No: 21394
 Order Date: 2019-11-04
 User: Pam Gross
 Phone: 989-460-7409

Ship Location: Reese Family Medicine
 12675 E Washington Rd
 Reese, MI 48757

Forms

Quantity: 100
 Paragon Dept No: 56048
 Dept Name:
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-340
 Item Description: Refusal to Consent to Vaccinate Adult
 Revision Date: 1/2019
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info:

Refusal to Consent to Adult Vaccination: 19 Years and Older

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

Patient Name: _____ ID# and DOB: _____

My health care provider, _____, has advised me that I should receive the following vaccines:

Recommended Vaccine	Declined	Reason for Refusal
Hepatitis A, HepA		
Hepatitis B, HepB		
Human Papillomavirus, HPV		
Influenza		
Measles/Mumps/Rubella, MMR		
Meningococcal Conjugate, MenACWY		
Meningococcal B, MenB		
Pneumococcal Conjugate, PCV13		
Pneumococcal Polysaccharide, PPV23		
Tetanus/diphtheria, Td		
Tetanus/diphtheria/pertussis, Tdap		
Varicella (chickenpox), Var		
Recombinant Zoster Vaccine (Shingrix), RZV		
Zoster Vaccine Live (Zostavax), ZVL		
Other		

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

- The purpose of the recommended vaccine(s).
- The risks of disease and the benefits and potential risks of the recommended vaccine(s).
- The possible consequence(s) of not receiving the recommended vaccine(s) may include contracting the illness the vaccine is intended to prevent and spreading the disease to others.
- My health care provider, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the CDC, and the Michigan Department of Health and Human Services strongly recommend that the vaccine(s) be given.

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

Signature _____ Date _____

Witness _____ Date _____

Adapted from the American Academy of Pediatrics (AAP) Revised: 1/9/2019