McLaren Business Products

McLaren Print System Order

Order No: 49591 Reprint Previous Order No: 5587
Order Date: 2019-10-18
User: Autumn Scherzer
Phone: 989-895-4648

Ship Location: East Medical Mall- Bay Regional Pediatrics Attn: Autumn
1456 W. Center Rd, Suite 1
Essexville, Michigan 48732
Forms
Quantity: 500
Paragon Dept No: 69640
Dept Name: Bay Pediatrics
Company Number: 810

Order Total Price: 0.00

Item Number: MM-122
Item Description: Immunization Waiver
Revision Date: 2/2014
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Ambulatory Care Center

IMMUNIZATION WAIVER

Vaccine-preventable diseases are still with us. In many cases, they cause disability or death. Immunizations are one of our most cost effective measures to protect children from harmful disease. An individual who has been exempted from a vaccination is considered susceptible to the disease or diseases for which the vaccination offers protection. A child may be subject to exclusion from the school or program, if the local and/or state public health authority advises exclusion as a disease control measure.

I object to to receiving the following vaccines: _____ _____
(First & Last Name) (Birthdate)

- ❑ Diphtheria, Tetanus, acellular Pertussis (DTaP) vaccine
- ❑ Diphtheria, Tetanus, (DT or Td) vaccine
- ❑ Haemophilus influenzae type B (Hib) vaccine
- ❑ Hepatitis A vaccine
- ❑ Hepatitis B vaccine
- ❑ Influenza
- ❑ HPV (male/female)
- ❑ Measles, Mumps, Rubella (MMR) vaccine
- ❑ Meningococcal vaccine
- ❑ Pneumococcal vaccine
- ❑ Polio
- ❑ Tdap
- ❑ Varicella (chickenpox) vaccine
- ❑ Zoster
- ❑ Other _____

My provider has explained to me and I understand the following:

- The **purpose** of the recommended vaccination
- The **risks and benefits** of the recommended vaccination
- A **possible consequence** of not allowing my child to receive the recommended vaccination is contracting the illness the vaccine is intended to prevent.
- My Provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention (CDC) have all strongly recommended that the vaccine(s) be given.

The health care provider has answered all of my questions.

Name: (PRINT) _____

Signature _____ Date: _____

Relationship (if other than Patient)

Witness _____

Patient Name

Date of Birth

MM-122 2/14 IMMUNIZATION WAIVER