advocare™

Vaccine Administration Record of Consent & Refusal to Vaccinate

Patient's Name: _____ Patient's DOB: ____/____/____

The immunizations checked in the left column are recommended for today's visit. If the vaccine is available, your signed consent is required after you review the vaccine information statement(s) and we have answered any questions.

Recommended Vaccines due Today	Not Available	Contraindicated	Declined	Accepted
☐ Hepatitis A	☐	☐	☐	☐
☐ Hepatitis B	☐	☐	☐	☐
☐ Haemophilus influenza type b	☐	☐	☐	☐
☐ Inactivated poliovirus	☐	☐	☐	☐
☐ Pneumococcal conjugate	☐	☐	☐	☐
☐ Rotavirus	☐	☐	☐	☐
☐ Measles-mumps-rubella	☐	☐	☐	☐
☐ Varicella	☐	☐	☐	☐
☐ Diphtheria, tetanus, pertussis	☐	☐	☐	☐
☐ Tetanus +/- Pertussis Booster	☐	☐	☐	☐
☐ Meningococcal serogroups ACWY	☐	☐	☐	☐
☐ Meningococcal serogroup B	☐	☐	☐	☐
☐ Human Papilloma virus	☐	☐	☐	☐
☐ Pneumovax	☐	☐	☐	☐
☐ Influenza	☐	☐	☐	☐
☐ Shingles	☐	☐	☐	☐
☐ Other (include name of vaccine):_____	☐	☐	☐	☐

I have been provided a copy of the appropriate Centers for Disease Control and Prevention Vaccine information material(s) and have read, or have had explained to me, information about the disease and the vaccines checked above. I have had a chance to ask questions which were answered to my satisfaction.

I understand the following:

- The **purpose** and the need for the recommended vaccine(s).
- The **risks and benefits** of the recommended vaccine(s).
- My medical provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention strongly recommend that the vaccine(s) be given according to recommendations, unless a medical contraindication check above prevents a vaccination opportunity today.
- If the vaccine(s) is/are not received according to the medically accepted schedule, **consequences** may include:
  - Contracting the illness the vaccine should prevent. The outcomes of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, paralysis, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well.
  - Transmitting the disease to others.
  - Requiring the patient to stay out of child care or school during disease outbreaks.

If the recommended vaccine above is checked as:

- Not Available - I will seek the vaccine elsewhere or reschedule as advised.
- Contraindicated - I understand why the vaccine should not be given today (or ever) or if I should reschedule.
- Declined - I refuse the vaccine at this time, however, I may readdress this issue with my medical provider at any time, or I may change my mind and accept vaccine in the future.
- Accepted - I am requesting that the vaccine be administered to me or the person named above.

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

Patient/Parent or Guardian's Signature:_____ Date Signed: ____/____/____

Printed Patient/Parent or Guardian's Name: _____

Physician/Provider's Signature:_____ Date Signed: ____/____/____