

# Refusal to Receive Vaccination

Patient's Name: \_\_\_\_\_ Patient's ID # \_\_\_\_\_

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

## Recommended

## Refused

Influenza (flu) Vaccine

Pneumococcal Polysaccharide Vaccine (PPV23)

I understand:

- < The **purpose** of and the need for the recommended vaccine(s).
- < The **risks and benefits** of the recommended vaccine(s).
- < My health care provider, the Advisory Committee on Immunization Practices, the Centers for Disease Control and Prevention, and the New York City Department of Health and Mental Hygiene all strongly recommend that the vaccine(s) be given.
- < If I do not receive the vaccine(s), the **consequences** may include increased risk of:
  - Getting sick from the illness the vaccine could prevent
  - Spreading the disease to others who could become ill, be hospitalized, or die as a result.
  - Being hospitalized for heart disease, stroke, pneumonia, or influenza, if I am 65 years of age or older.
  - Death, if I am 65 years of age or older.

Nevertheless, I have decided to refuse the vaccine(s) recommended above by checking the appropriate box under the column titled "Refused".

I know that my failure to follow these recommendations for vaccination may endanger my health or the health of people I come in contact with.

I know that, even though I refuse to be vaccinated now, I can **change my mind at any time** and accept vaccination in the future.

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

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_