# Vaccination Declination Form

## PATIENT INFORMATION

Name: _____ Age: _____

Medical record number: _____ Date: _____ dd / mm / yyyy

## VACCINATION INFORMATION

Vaccine type: _____ Manufacturer: _____

Lot number: _____ Scheduled vaccination date: _____ dd / mm / yyyy

## REASON FOR DECLINING VACCINATION

**Reason for declining vaccinationCheck all that apply:**

Reason for declining vaccination

- [ ] Personal or religious beliefs
- [ ] Medical contraindications
- [ ] Concerns about vaccine safety or efficacy
- [ ] Previous adverse reaction to vaccine

## PATIENT ACKNOWLEDGEMENT

Acknowledgement:

I have received and reviewed information about the risks and benefits of the vaccine. Despite this, I am choosing to decline the vaccination at this time. I understand that declining this vaccination may result in the following risks:Increased risk of contracting the diseaseIncreased risk of spreading the disease to others, including those who may be vulnerable to severe illnessPotential exclusion from certain activities or facilities where vaccination is required

## PATIENT DECLARATION

I acknowledge that I have read and fully understand the information provided to me about the risks of declining the vaccination. I understand that I can change my mind at any time and receive the vaccination in the future. I release the healthcare provider, their staff, and the healthcare facility from any liability for any adverse health outcomes that may result from my decision to decline the vaccination.

Patient's signature:
Date: _____ dd / mm / yyyy

## WITNESS INFORMATION

Witness name: _____

Witness signature:
Date: _____ dd / mm / yyyy

## HEALTHCARE PROVIDER STATEMENT

Statement:

Healthcare provider's signature:

Date: _____ dd / mm / yyyy

## ADDITIONAL NOTES (IF ANY)

Specify below: