

McLaren Print System Order

Order No: 47514 Reprint Previous Order No: 5587
Order Date: 2019-08-06
User: nancy lis
Phone: 586-294-5210

Ship Location: McLaren Lakeshore Medical Center
33720 Harper Avenue
Clinton Twp, MI 48035

Forms

Quantity: 100
Paragon Dept No: 72650
Dept Name: McLaren Lakeshore Medical Center
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 receiving the following vaccines: _____

- 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
- IPV (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