McLaren Business Products

McLaren Print System Order

Order No: 63152 Reprint Previous Order No: 21394
Order Date: 2021-06-22
User: Michele Lubick
Phone: 586-263-0320

Ship Location: McLaren Macomb Family Medicine-Michele
16700 21 Mile Rd., Suite 101
Macomb, MI 48044
Forms
Quantity: 100
Paragon Dept No: 71600
Dept Name: McLaren Macomb Family Medicine
Company Number: 810

Order Total Price: 0.00

Item Number: MM-340
Item Description: Refusal to Consent to Vaccinate Adult
Revision Date: 1/2019
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

Refusal to Consent to Adult Vaccination: 19 Years and Older

This is a tool for provider practices to use for documentation in the patient's medical record. This is not an immunization waiver form. Contact your local health department for more information. Remember to document vaccine refusal in the Michigan Care Improvement Registry (MCIR).

Patient Name: ______________________ ID# and DOB ______________

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

Recommended Vaccine	Declined	Reason for Refusal
Hepatitis A: HepA		
Hepatitis B: HepB		
Human Papillomavirus: 9vHPV		
Influenza		
Measles/Mumps/Rubella: MMR		
Meningococcal Conjugate: MenACWY		
Meningococcal B: MenB		
Pneumococcal Conjugate: PCV13		
Pneumococcal Polysaccharide: PPSV23		
Tetanus/diphtheria: Td		
Tetanus/diphtheria/pertussis: Tdap		
Varicella (chickenpox): Var		
Recombinant Zoster Vaccine (Shingrix): RZV		
Zoster Vaccine Live (Zostavax®): ZVL		
Other		

I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement(s) explaining the vaccine(s) and the disease(s) they prevent. My health care provider has explained to me and I understand the following:

- The **purpose** of the recommended vaccine(s).
- The **risks** of disease and the **benefits and potential risks** of the recommended vaccine(s).
- The **possible consequence(s)** of not receiving the recommended vaccine(s) may include contracting the illness the vaccine is intended to prevent and spreading the disease to others.
- My health care provider, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the CDC, and the Michigan Department of Health and Human Services **strongly recommend** that the vaccine(s) be given.

My health care provider has answered all my questions.
I know that I may change my mind and accept vaccination in the future.
I accept sole responsibility for any consequences that result from not being vaccinated.
I acknowledge that I have read this document in its entirety and fully understand it.

______________________ ________
Signature Date

______________________ ________
Witness Date

Adapted from the American Academy of Pediatrics (AAP) Revised: 1/9/2019

MM-340 (1/2019)