

Vaccination Declination Form

Patient information

Name:

Age:

Medical record number:

Date:

Vaccination information

Vaccine type:

Manufacturer:

Lot number:

Scheduled vaccination date:

Reason for declining vaccination

Check all that apply:

- Personal or religious beliefs
- Medical contraindications
- Concerns about vaccine safety or efficacy
- Previous adverse reaction to vaccine
- Others (please specify):

Patient acknowledgement

I, _____, have been advised by my healthcare provider to receive the _____ vaccination. I understand that the vaccination is recommended to protect me and others from the spread of _____.

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 disease.
- Increased risk of spreading the disease to others, including those who may be vulnerable to severe illness.
- Potential 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:

Witness information


Name:

Signature: 

Date:

Healthcare provider statement

I, _____, have discussed with the patient the benefits and risks of receiving the _____ vaccination. The patient has indicated understanding of the information provided and has chosen to decline the vaccination.

Healthcare provider's signature: 

Date:

Additional notes

Empty box for additional notes.