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, _____[Patient's name]_____, have been advised by my healthcare provider to receive the _____[Name of vaccine]_____ vaccination. I understand that the vaccination is recommended to protect me and others from the spread of _____[Disease]_____.

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, _____[Healthcare provider's name]_____, have discussed with the patient the benefits and risks of receiving the _____[Name of vaccine]_____ vaccination. The patient has indicated understanding of the information provided and has chosen to decline the vaccination.	
Healthcare provider’s signature:	
Date:	
Additional notes	