Mid Island Therapy Associates is

ALL ABOUT KIDS™

Evaluations & Therapy Services

VACCINATION FORM

Last:	First:	Middle:	Date Of Birth:	Date Of Exam:

Address:

Street City State Zip Code

Home Phone: **Cell Phone:** **Job Title:**

IMMUNIZATION RECORD

Hepatitis B: (either provide proof of immunization series, a positive titre, or a signed document of refusal of vaccine
Vaccinated _____
Diphtheria: Vaccinated_____
Tetanus: Vaccinated_____
Pertussis: Vaccinated _____
Varicella: Vaccinated _____
Influenza: Vaccinated _____
Measles/Mumps/Rubella: _____

(Measles vaccine is required as follows: proof of two doses of vaccine, a positive titer, or physician certification of disease if born on or after January 1, 1957. A Rubella titer is required unless a positive titer is on record)

VACCINATION REFUSAL- To be completed by patient if ANY of the above recommended vaccinations have been refused.

I understand:

- The **purpose** of and the need for the recommended vaccine(s).
- The **risks and benefits** of the recommended vaccine(s).

I know that my failure to follow these recommendations for vaccination may endanger my health or the health of people I come in contact with.

I know that, even though I refuse to be vaccinated now, I can **change my mind at any time** and accept vaccination in the future.

I acknowledge that I have read this refusal form in its entirety and fully understand it.

Patient Signature _____ **Date:** _____

_____ _____

Physician's Signature License Number

_____ _____

Telephone Number Address