



# Haverford College

## DECISION NOT TO VACCINATE

Haverford Health Services Pre-Matriculation Immunization Policy follows the guidelines of the PA State Mandatory Vaccinations for School Entrance Policy, CDC, Advisory Committee on Immunization Practices (ACIP), and American College Health Association (ACHA) recommendations for entry to school.

By signing below, I \_\_\_\_\_ (print name here) acknowledge that I have read the CDC Vaccination Information Sheets, and given an opportunity to ask questions, and advised to receive the following vaccines:

**Tetanus, Diphtheria and Pertussis (Tdap), one dose within past 10 years**

**Varicella, 2 doses**

**Measles, Mumps and Rubella (MMR), 2 doses**

**Hepatitis B, 3 doses**

**Meningitis (Meningococcal vaccine A, C, Y and W-135 or Menactra)**

**Polio (OPV or IPV), 4 doses**

At this time, I refuse to receive any disease preventative vaccines (CIRCLE WHY)  
Medical, Religious, Philosophical Beliefs \_\_\_\_\_ (initial)

I understand that without receiving immunizations puts me at risk for vaccine preventable illnesses. \_\_\_\_\_ (initial)

I am aware that failure to follow these vaccine recommendations endangers the public health of others, and I may have to leave campus if I contract any such illness. \_\_\_\_\_ (initial)

If I were to develop a rash, fever, or become ill in any way, or notice anything different about my health, I will need to seek immediate medical attention. \_\_\_\_\_ (initial)

I am aware that I can confer with a health care provider at any time if I have questions about vaccinations and/or would like to receive them in the future. \_\_\_\_\_ (initial)

**Student Signature:** \_\_\_\_\_ **Student ID:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Healthcare Provider Witness** \_\_\_\_\_ **Date:** \_\_\_\_\_