Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please indicate the serology and/or vaccine refused

|  |  |  |
| --- | --- | --- |
|  | Serology | Vaccine |
| Diphtheria/Tetanus/Pertussis (dTpa) |  | 🗆 YES |
| Hepatitis A | 🗆 YES | 🗆 YES |
| Hepatitis B | 🗆 YES | 🗆 YES |
| Influenza |  | 🗆 YES |
| Measles/Mumps/Rubella | 🗆 YES | 🗆 YES |
| Varicella (Chickenpox vaccine) | 🗆 YES | 🗆 YES |
| Other *(please specify)………………* | 🗆 YES | 🗆 YES |

Declaration for refusing recommended vaccination or screening

I have discussed the benefits and risks of vaccination with the immunisation provider and have considered the information given. I have also been given the opportunity to discuss any concerns about vaccination with the immunisation provider.

I understand that by refusing a vaccine or screening I may remain non-immune to vaccine preventable diseases and continue to be a potential source of infection to patients, staff and visitors.

As a result of refusing a vaccine or screening I will be advised of management options which may include limited or no opportunities for clinical role in WHN.

I understand that in the event of reconsideration and subsequent compliance with the Immunisation Guidelines that decisions made in relation to clinical roles will be reconsidered.

Reason for declination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_