

Deansgrange Medical Centre
2 Clonkeen Road, Blackrock,
Co. Dublin.

Immunisation Refusal Form

Child's name & DOB: (place addressograph here)

Mother's name: _____ **DOB:** _____

I have been advised by my GP or Practice Nurse that this/these vaccine/s have been recommended by the HSE as part of the Primary Childhood Immunisation Schedule. However, I wish to decline consent for my child to receive _____ vaccine/s.

Parent/legal guardian signature: _____

Date: _____

GP/Practice Nurse signature: _____

Date: _____