Beth Israel Lahey Health
Mount Auburn Hospital

Hepatitis B Vaccine Administration Waiver

I request that the administration of the Hepatitis B vaccine recommended to be administered by 24 hours of age not be performed on _____ prior to discharge from Mount Auburn Hospital.

Since the introduction of the Hepatitis B vaccine in 1982, there has been a 90% decrease in new Hepatitis B infections. Despite this vaccination effort, approximately 1000 newborns contract Hepatitis B every year. Research shows that vaccinating a newborn within 24 hours will nearly eliminate the transfer of Hepatitis B virus from mother to baby. For this reason, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP) and the American Academy of Pediatrics (AAP) recommend that all newborns with a birth weight of greater than 2000 grams (4 lbs 6 oz) receive the Hepatitis B vaccine by 24 hours of age.

I have received the CDC's Vaccine Information Statement for Hepatitis B vaccine and understand that Hepatitis B is a serious viral disease that causes liver injury. Once Hepatitis B infection is acquired by the newborn, it can cause either an acute illness or it can lead to a lifelong chronic illness potentially resulting in liver failure. Chronic Hepatitis B infection will result in 1 in 4 newborns dying from this illness over the course of their lives.

I hereby release Mount Auburn Hospital, its employees, staff, physicians, officers, directors and agents from liability for any harm and other consequences related to my refusal of the administration of the Hepatitis B vaccine for my infant. I agree and accept responsibility for informing my infant's pediatrician and other health care providers that my infant has not received the Hepatitis B vaccine.

By signing below I acknowledge that I have read this document in its entirety, have had the opportunity to ask questions, and fully understand it.

Nevertheless, I have decided at this time to decline or defer the Hepatitis B vaccine for my newborn. I know that failure to follow the recommendation of the ACIP of the CDC and the AAP may endanger the health and life of my baby.

Parent or Authorized Person's Signature:

_____	_____	_____	_____ AM/PM
Parent (or person authorized to sign for patient)	Print Name	Date	Time

Witness to Parent or Authorized Person's Signature:

_____ ❑ RN ❑ MD	_____ ❑ RN ❑ MD	_____	_____ AM/PM
Witness Signature	Print Name	Date	Time