Beth Israel Lahey Health
Mount Auburn Hospital

Vitamin K Administration Waiver

REFUSAL OF RECOMMENDED NEWBORN TREATMENT

STAMP PATIENT PLATE HERE

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I request that the administration of Vitamin K for the prevention of bleeding disorders not be performed on _____ prior to discharge from Mount Auburn Hospital.

I refuse administration of Vitamin K, which prevents bleeding disorders. I have been informed that administration of Vitamin K is recommended by both the Center for Disease Control (CDC) and the American Academy of Pediatrics (AAP). Understand that Vitamin K deficiency can cause severe bleeding, which if it occurs in the baby's brain will cause permanent brain damage to my baby.

I am aware that this action is not consistent with the medical standards for newborns established by the CDC and the AAP and is against the advice of my infant's attending physician. I have been informed of the purpose and benefits of the Vitamin K administration and the risks and complications that may result from refusal of Vitamin K administration for my infant.

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 Vitamin K for my infant. I agree and accept responsibility for informing my infant's pediatrician and other health care providers that specific administration of Vitamin K has **not** been performed.

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 administration of Vitamin K injection for my newborn. I know that failure to follow this recommendation by the CDC and the AAP may endanger the health and life of my baby.

Parent or Authorized Person's Signature:

_____ _____ ___ / ___ /___ _____ : _____

Parent *(or person authorized to sign for patient)* | Print Name | Date | Time *(24 hours)*

Witness to Parent or Authorized Person's Signature:

_____ ❒ **RN** ❒ **MD** _____ ❒ **RN** ❒ **MD** ___ / ___ /___ _____ : _____

Witness Signature | Print Name | Date | Time *(24 hours)*