COVID-19 VACCINE DECLINATION FORM

Patient/Resident/Staff Member Information:

First Name: _____ Last name: _____

Medical Record #: _____ ☐ N/A - staff member

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male

I acknowledge that I have read, or had explained to me, the Coronavirus Disease (COVID-19) General Information handout and the Emergency Use Authorization (EUA) Fact Sheet regarding the COVID-19 vaccine.

I have had the opportunity to ask questions, which have been answered to my satisfaction and understand the benefits and risks of the vaccination as described.

I understand that if I decline the vaccine, I may change my mind and request to be vaccinated at a later date, with the understanding that the vaccination will be based on the availability of the COVID-19 vaccine at that time.

_____ I wish to refuse the COVID-19 vaccination (or refuse for the person named above for whom I am authorized to make this request). I understand that I may change my mind and request to be vaccinated later.

☐ I certify that I am (a) the patient/resident/staff member and at least 18 yrs of age or (b) the representative of or the legal guardian of the patient/resident named above. I acknowledge that in making this decision I have had a chance to ask questions and that such questions were answered to my satisfaction.

_____ Date: _____
Patient/Resident/Staff Member Signature

_____ Date: _____
Legal Representative Signature

PRINT Legal Representative Name: _____

Relationship to patient/resident: _____

If VERBAL DECLINATION was received for the patient/resident:

_____
Print name of person providing verbal declination

_____ Date: _____
Staff Member Signature (person who received verbal declination)