Image

**COVID-19 VACCINE DECLINATION FORM**

**First Name**: **Last Name**:

**Medical Record #:** ☐ **N/A- Staff Member**

**Date of Birth**: **Gender: ☐ Female ☐ Male**

I understand that [INSERT FACILITY NAME] recommends that I receive the COVID-19 vaccine to protect myself, residents, staff, and others in the facility and surrounding community. [INSERT FACILITY NAME] has provided me information regarding the benefits and risks of the COVID-19 vaccine and provided me the opportunity to ask questions.

**I acknowledge the following facts (please read and check each box):**

☐ I have received and reviewed the Centers for Disease Control and Prevention’s (CDC) Vaccine Information Statement(s) or Emergency Use Authorization information explaining the Vaccine(s) and the disease(s) they prevent.

☐ I understand that the COVID-19 vaccine is free of charge.

☐ I understand that the COVID-19 is a serious respiratory virus. It has infected and killed hundreds of thousands of people and has caused many more hospitalizations. It is particularly dangerous to the residents of long-term care facilities and people with chronic medical conditions.

☐ I understand that by getting the COVID-19 vaccine, I (or the recipient of the vaccine) can protect the residents, employees and family of this facility from COVID-19, its complications, and death.

☐ I understand that the COVID-19 vaccination does not cause COVID-19.

☐ I understand that by not getting the COVID-19 vaccine, I (or the recipient of the vaccine) will have to continue to adhere to CDC guidance for unvaccinated individuals in the healthcare facility. For staff, this means undergoing routine testing and for residents, this means only participating in activities and dining with social distancing and masks.

☐ Despite these facts, I am choosing to decline the COVID-19 vaccine.

**MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT AND REFUSE THE VACCINE PROPOSED WITHIN.**

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Signature of Staff, Resident or Representative Date

*Please retain this form for your records*