Refusal to Consent to Vaccination

This is a toolfordocumentationinthepatient'smedicalrecord.Thisisnotawaiver form.

Name _____ **Date of Birth** _____

I have been advised about receiving the following vaccine(s):

- COVID-19 Vaccine, including all applicable doses of the SARS-CoV-2 Vaccine.

I understand and refuse the administration of the Vaccine, including any and all recommended doses. I acknowledge that 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.

The following have been explained to me:

- The purpose of the Vaccine.
- The benefits of the Vaccine.
- The risks of not receiving the Vaccine, including, but not limited to the fact that I may contract the illness the Vaccine is intended to prevent, and may transmit such illness to others. There may be other unknown risks that cannot be identified at this time, and I fully accept and assume responsibility for these risks.

I also acknowledge that:

- I have had the opportunity to have all my questions related to the Vaccine answered and the answers are to my satisfaction.
- I may ask further questions, change my decision, consent to the Vaccine at any time and receive the Vaccine based on availability.
- I accept sole and complete responsibility for any consequences to my general health or to others as a result of the Vaccine that I declined, and do hereby release PharmScript and the skilled nursing facility where I reside from all responsibility for any ill effects that may result from my refusal of the administration of the Vaccine as identified in this form.

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

Signature _____ **Date** _____

Resident signature OR Signature/Printed Name of Health POA OR Name of Health POA/verbally acknowledged by licensed staff (sign & print name & credentials)

_____ **Date** _____