Vaccine Administration Record (VAR) COVID-19 Vaccine Declination Form

First name:_____ **Last name:** _____

Date of birth:_____ **Age:**_____ □ □

Gender: **Female** **Male**

LTCF Name:_____ **Address:**_____

City:_____ **State:**_____ **ZIP code:**_____ **Patient Email address:** _____

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves.

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.

I understand the risks and benefits associated with refusing the vaccine have received, read and/or had explained to me the EUA Fact Sheet on the vaccine (attached)

I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of this decision

My signature below acknowledges that I have read and understand this document and refuse the COVID vaccine proposed, I also understand that if I decide later to be vaccinated, it is my responsibility to request said vaccination from the facility

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Print Name:_____

Patient/Authorized Person signature:_____ **Date:**_____