

# COVID-19 Vaccination Consent / Refusal Form



You are being offered the opportunity to receive a COVID-19 Vaccine and must notify the Facility of your choice to receive or refuse to receive the COVID-19 Vaccine. Every resident and employee must fill out this form even if choosing not to obtain the COVID-19 Vaccine.

**SECTION A** Please print clearly.

Last name:		M.I.:	First Name:		Home address: (Including City, State and ZIP)			
Date of birth:		Age:		Gender:		Phone Number:		
				<input type="checkbox"/> Female <input type="checkbox"/> Male				
				<input type="checkbox"/> Non-Binary/Other				
<b>Authorized Power of Attorney (POA) / Legal Guardian Name:</b>				<b>Medical Director's Name:</b>				
Last name:		M.I.:	First:		Last name:		M.I.:	First:
City		State		Zip		Facility Name:		<input type="checkbox"/> Resident <input type="checkbox"/> Staff
								<input type="checkbox"/> Other

**SECTION B** Please choose one of the following:

I consent to receiving the COVID-19 Vaccine.

By signing below, I certify that I am: (a) the patient and at least 18 years of age, or (b) the legal representative of the patient, or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or is unable to consent for themselves. I give my consent to the Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each a "Provider"), to administer a COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving the COVID-19 vaccine. I understand the risks and benefits associated with the COVID-19 vaccine and have received, read and/or had explained to me the Vaccine Information Statement and/or the Emergency Use Authorization data sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Facility, Pharmacy, and Provider, and their 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, in connection with, or in any way related to the administration of the COVID-19 Vaccine.

I have already received a COVID-19 Vaccine.

By signing below, I certify that I have already received the COVID-19 Vaccine. If the Vaccine I received requires two doses, I certify that I have either already received both doses on the schedule required or that I have plans to receive the second dose in the required time period. I further agree to notify Facility if I fail to receive the second dose of the COVID-19 Vaccine, if required by the manufacturer.

I refuse to receive the COVID-19 Vaccine.

By signing below, I acknowledge that a COVID-19 Vaccine is being offered to me, but I am refusing to receive it. I certify that the risks and benefits associated with the COVID-19 vaccine have been explained to me and I have received, read and/or had explained to me the Vaccine Information Statement and/or the Emergency Use Authorization data sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I understand that Facility might not provide me another opportunity to receive a COVID-19 Vaccine and I hereby release and hold harmless Facility and 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, in connection with, or in any way related to my refusal.

**SECTION C** Authorization to Request Payment

I do hereby authorize ICP, Inc to release information and request payment. I certify that the information given by me in applying for payment under Medicare, Medicaid, or commercial insurance is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

**SECTION D** Disclosure of Records

I understand that ICP, Inc. may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at ICP, Inc. (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that ICP, Inc. will use and disclose my health information as set forth in the ICP, Inc. Notice of Privacy Practices (copy is available online or by requesting a paper copy from ICP, Inc.). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

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

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

