

**HOPKINS CENTER FOR REHABILITATION AND HEALTHCARE**

**COVID-19 FACILITY VACCINATION FORM**

**Resident/Staff member information:**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Medical record number if applicable: \_\_\_\_\_ O N/A Staff member

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

I acknowledge that I have read or had explained to me the Emergency Use Authorization (EUA) fact sheet regarding COVID-19 vaccine.

I have had the opportunity to ask questions which have been answered to my satisfaction and I understand the benefits and risk 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 the 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 resident/staff member and at least 18 years of age or (b) the representative of or he legal guardian of the resident/staff member 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.

Resident or staff member signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print legal representative name: \_\_\_\_\_

Relationship to resident: \_\_\_\_\_

**IF VERBAL DECLINATION:**

Print name of person providing verbal declination: \_\_\_\_\_

Staff member signature (person received verbal declination):

\_\_\_\_\_ Date: \_\_\_\_\_

**New Admissions and New Hires:**

Based upon questions asked at the pre-admission/pre-employment screening process, the resident/personnel are eligible to receive the vaccine:  Yes  No (Reason: \_\_\_\_\_)

Have you received any doses of the COVID-19 vaccine?  Yes  No

If yes, location received: \_\_\_\_\_ Vaccine received:  Pfizer  Moderna  J & J

Do you wish to receive the COVID-19 vaccine?  Yes  No

**If yes, documented efforts to obtain the COVID-19 vaccination are on the next page.**

**If no, the resident/personnel has been instructed that if they change their mind in the future, they can inform the facility and the facility will arrange for vaccination.**

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**COVID-19 FACILITY VACCINATION FORM**

**Documented Efforts to obtain the COVID-19 vaccination:**

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Date: \_\_\_\_\_ Efforts: \_\_\_\_\_

Comments: \_\_\_\_\_

Resident/Personnel has received their first dose of the vaccine: Date: \_\_\_\_\_

Scheduled second visit: \_\_\_\_\_ Vaccine received:  Pfizer  Moderna  J & J

Resident/Personnel is fully vaccinated as of : Date: \_\_\_\_\_

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