Refusal to Stay for Observation After Receiving a COVID-19 Vaccine

Form for Adults Age 18+

***This form is for adult vaccine recipients only and shall be maintained by the Clinic**

***All children less than 18 years of age must stay for the minimum 15 minute observation period following vaccination to be observed for immediate adverse effects**

Name of recipient: Date vaccine administered:

Name of vaccine: Time vaccine administered:

*A healthcare professional has informed me that I should remain for 15 minutes after receiving COVID-19 vaccine in order to be observed for signs and symptoms of an immediate adverse reaction.

*I have also been advised of the risks of an allergic reaction to the vaccine, including the inability to breathe.

*I acknowledge that I have been properly informed about the potential side effects of taking the vaccine and the risks of leaving before the recommended fifteen minutes observation.

*Given the recommendations, and understanding of the potential adverse consequences from taking the vaccine, I decline to remain for a fifteen minute period of observation.

*I assume full responsibility for any adverse consequences which arise from my leaving prior to the recommended observation period, including a potential severe allergic reaction to the vaccine which may hinder my ability to breathe and may require emergency care.

Signature of Recipient:_____ Date: Time:

Printed name of recipient:

Signature of Vaccinator:_____ Date: Time:

Refusal to Stay for Observation After Receiving an Influenza Vaccine

Form for Adults Age 18+

***This form is for adult vaccine recipients only and shall be maintained by the Clinic**

***All children less than 18 years of age must stay for the minimum 15 minute observation period following vaccination to be observed for immediate adverse effects**

Name of recipient: Date vaccine administered:

Name of vaccine: Time vaccine administered:

*A healthcare professional has informed me that I should remain for 15 minutes after receiving Influenza vaccine in order to be observed for signs and symptoms of an immediate adverse reaction.

*I have also been advised of the risks of an allergic reaction to the vaccine, including the inability to breathe.

*I acknowledge that I have been properly informed about the potential side effects of taking the vaccine and the risks of leaving before the recommended fifteen minutes observation.

*Given the recommendations, and understanding of the potential adverse consequences from taking the vaccine, I decline to remain for a fifteen minute period of observation.

*I assume full responsibility for any adverse consequences which arise from my leaving prior to the recommended observation period, including a potential severe allergic reaction to the vaccine which may hinder my ability to breathe and may require emergency care.

Signature of Recipient:_____ Date: Time:

Printed name of recipient:

Signature of Vaccinator:_____ Date: Time: