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Patient’s Name (print)

**COVID-19 VACCINE DECLINATION FORM**

**A. Acknowledgement of Receipt of Education on COVID-19 Vaccine and Understanding of Risk**

I UNDERSTAND that I am at risk of acquiring COVID-19 infection. I understand that there is an emergency use authorized vaccine available to protect against COVID-19. I have been provided education on the risks and benefits of the COVID-19 vaccine and I have been given the opportunity to be vaccinated with the PfizerBioNTech, Moderna, or Johnson and Johnson’s Janssen COVID-19 vaccine at no charge to me.

☐ I DECLINE the COVID-19 vaccine. I understand that by declining the vaccine, I continue to be at risk of acquiring COVID-19, a serious disease that can result in death. If, in the future, I want to be vaccinated, I can receive the vaccine.

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Signature - 1st Trimester Date

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Signature - 2nd Trimester Date

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Signature - 3rd Trimester Date

Reason for Declination: ☐ I don’t consider myself at high risk of complications if I contract COVID-19

 ☐ I’m concerned about side effects

 ☐ I’m concerned that it will affect my fertility (having babies in the future,

 menstrual cycle, etc.

 ☐ I rather vaccinate after I have my baby

 ☐ I don’t think the vaccine works

 ☐ I don’t understand how the vaccine works

☐ I don’t consider myself at risk because I recently recovered from COVID-19

 ☐ Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Paciente’s Nombre

**Forma de Declinación de la vacuna contra el COVID-19**

**A. Reconocimiento de haber recibido educación en COVID-19 Vacuna y entendimiento de riesgo**

Yo entiendo que estoy en riesgo de contraer la infección de COVID-19. Entiendo que hay una vacuna con autorización de uso de emergencia para protegerme contra el COVID-19. Me han proveído información acerca de los riesgos y beneficios de la vacuna contra el COVID-19 y se me ha dado la oportunidad de vacunarme con la vacuna de PfizerBioNTech, Moderna, o Johnson and Johnson’s Janssen a ningún costo.

☐ Yo RECHAZO la vacuna contra el COVID-19 en este momento. Yo entiendo que, al rechazar esta vacuna, yo continúo estando en riesgo de contraer COVID-19, una enfermedad seria que podría resultar en muerte. Si en un futuro decido vacunarme contra el COVID-19, podre hacerlo.

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Firma – Primer Trimestre Fecha

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Firma – Segundo Trimestre Fecha

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Firma – Tercer Trimestre Fecha

Razón por rechazar la vacuna: ☐ No considero estar en riesgo de complicaciones de COVID-19

☐ Me preocupan los efectos secundarios de la vacuna

☐ Me preocupa que la vacuna afecte mi fertilidad (menstruación, poder

 tener bebes en el futuro, etc.)

☐ Prefiero vacunarme después de tener a mi bebe

 ☐ No creo que la vacuna funcione

 ☐ No entiendo cómo funciona la vacuna

☐ No me considero en riesgo porque recientemente me recupere de

 COVID-19

 ☐ Otra (especifique):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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