

**COVID-19 VACCINATION DECLINATION FORM**

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| **Name (Print)**: | **Department** |
| Mount Nittany Health encourages all employees to be vaccinated against a variety of communicable diseases, including COVID-19.  Mount Nittany Health has recommended that I receive the COVID-19 vaccination to protect myself, other patients, and the community.  I acknowledge that I am aware of the following facts:   * COVID-19 is a serious respiratory disease that has killed over 1 million US citizens since the beginning of 2020. * COVID-19 vaccination is recommended for me and everyone to prevent COVID-19 disease and its complications, including death. * If I contract COVID-19, I will shed the virus for 48 hours before COVID-19 symptoms appear. My shedding the virus can spread COVID-19 infection to others in this facility. * If I become infected with COVID-19, even when my symptoms are mild, I can spread the severe illness to others. * If I become infected with COVID-19, even if I remain asymptomatic, I can spread the severe illness to others. * I cannot get the COVID-19 disease from the vaccine.   The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:   * Patients * Direct Care Staff * My Family * My Community   Despite these facts, I am choosing to decline COVID-19 vaccination right now. I understand that I may change my mind at any time and accept the COVID-19 vaccination.  Reason for Declination (please select only 1):  My religious beliefs prohibit vaccination. Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have a severe allergy or medical contraindication to receiving the COVID-19 vaccine. (must provide physician documentation): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other (please explain – i.e. personal preference):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have read and fully understand the information on this declination form and acknowledge that Mount Nittany Health may, in its sole discretion, modify or update its vaccination requirements at any time in the future.   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Signature |  |  |  | Date: |  |  | | |

(06/2023)