Oregon Coast Community College – Nursing & Allied Health Department

COVID-19 Vaccination Declination Form

For Nursing & Allied Health faculty, students and staff

Section 1: Personal Information

Name:

Student ID#:

Phone Number:

Email Address:

Date:

Section 2: COVID-19 Vaccination Education Acknowledgment

I understand that the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), clinical partners and Oregon Coast Community College recommend that all healthcare workers receive the COVID-19 vaccination series to protect themselves, their families, colleagues, and the vulnerable populations they serve.

I acknowledge that:
- COVID-19 is a serious and potentially life-threatening illness.
- I may be contagious before showing any symptoms.
- The COVID-19 vaccine is effective at reducing the severity of illness, hospitalization, and transmission.
- Vaccination helps protect patients, especially those who are immunocompromised or at higher risk for severe disease.

☐ I have received and reviewed the educational material provided regarding the COVID-19 vaccine.

☐ I have had the opportunity to ask questions and receive satisfactory answers.

Section 3: Reason for Declination (Check all that apply)

☐ I have a medical contraindication (e.g., documented severe allergic reaction).

☐ I am allergic to an ingredient in the vaccine.

☐ I have previously experienced an adverse reaction.

☐ I believe the vaccine is not effective.

☐ I do not believe I am at risk of contracting COVID-19.

☐ I have religious or personal beliefs that prevent vaccination.

☐ Other (please specify):

_____

Section 4: Acknowledgment of Risk and Responsibility

By declining the COVID-19 vaccination, I understand and accept the following:

- I may be required to wear a mask and/or follow additional infection control precautions during patient care or while in clinical areas.
- I may be subject to periodic testing or reassignment during an outbreak or high-risk period.
- I may be asked to stay home or follow quarantine procedures if exposed to COVID-19.
- I may increase the risk of transmitting COVID-19 to patients, colleagues, and my family.

I acknowledge that I am voluntarily declining the COVID-19 vaccine despite the risks described above.

Signature: _____

Date: _____

Section 5: For Administrative Use Only

☐ Declination reviewed by: _____

☐ Person educated on infection control policies

☐ Masking and testing policies discussed

☐ Infection control consultation offered_