COVID-19 PATIENT VACCINATION DISCLOSURE

Vaccination Dates:____

Vaccine Received:_________________________ Doses Received:________________________

By signing this document, I acknowledge that the answers I have provided above are true and accurate. I have provided a copy of my vaccination record to have attached to my patient file.

I understand that I will continue to undergo a temperature screening for extra precautions.

______________________________ ____________
Patient or Legal Representative Signature Date

____
Print Patient or Legal Representative Name/Relationship

__________________________ ____________
Witness Signature (optional) Date

Below is for office use only:

Patient Temperature:___________________________ PO2:

Guest Temperature:____________________________ PO2:

Guest Vaccination or Covid-19 Screening received? Y N

***Guest vaccination record received or Covid-19 Screening Form must be on file to enter the building.**

Asked to go home: ☐ Yes, time:____________________ am pm ☐ No