REFUSAL OF RABIES POST-EXPOSURE PROPHYLAXIS

I hereby acknowledge that I have been informed of the reasons that Rabies Post-Exposure Prophylaxis has been recommended for:

______________________________ __________ ____________________

Name DOB Health Card Number

I understand the risk of refusing Rabies Post-Exposure Prophylaxis. In particular, I understand that rabies in human is fatal. I accept and assume all responsibility for this decision.

____ ____________________

☐ **Patient** ☐ **Parent** ☐ **Caregiver** ☐ **Legal Guardian** **Date**

____ ____________________

Witness/CHN **Date**

____ ____________________

Medical Health Officer or Designate **Date**