



INFLUENZA VACCINE DECLINATION FORM

The healthcare facility has requested you receive an influenza vaccination to protect patients you serve, family members and yourself.

I understand that I am at risk for exposure to influenza and maybe at risk for developing influenza infection. I have been given the opportunity to be vaccinated with the influenza vaccine at no charge. However, I decline the influenza vaccine at this time. I understand that by declining the vaccine I may continue to be at risk for influenza infection. Should I decide that I want to be vaccinated with the influenza vaccine, I should notify Employee Health and I can receive the vaccine, if available, at no charge.

_____ I have already received the 2017 / 18 influenza vaccine and have provided documentation (as listed below).

Documentation of flu vaccination includes: a copy of informed consent for immunization signed from medical office, or official statement from administration site noting location of shot, date of shot, type of vaccine, lot #, and name of who gave vaccine.

I am aware that by not taking the influenza vaccine that I am required to wear a surgical face mask anytime that I am within 6 feet of a patient care area. This will begin November 1, 2017. Remaining in effect until flu season officially ends.

Please select a reason from below for declining the influenza vaccine:

- _____ I am allergic to eggs
- _____ I had a severe reaction to an influenza vaccine in the past
- _____ I am afraid of getting the flu vaccine
- _____ I do not like getting shots
- _____ Other reason: (List) _____

Please complete all sections below. Information is mandatory for clearance.

Name: _____ School _____
 Last 4 of SSN# _____ Program _____
 DOB: _____ Vaccine date: _____