Heritage Nursing Agency

704 Tuolumne Street, Vallejo CA 94590
Phone Number: (707) 641-1051
Email Address: staffing@heritagenursesvallejo.com

Name: _____ Date ____/____/_____

Flu Vaccination Acceptance/Declination

Acceptance: ☐

I, _____ consent to the influenza vaccine to be given to me.

I understand that side effects are minimal with the possibility of soreness at the injection site.

I am not allergic to eggs nor have I been diagnosed with Guillain-Barre Syndrome or am I currently pregnant.

The clinic is not liable for any side effects resulting from the influenza vaccine nor is the nurse administering the medication responsible for any side effects resulting from the influenza vaccine.

I have read the statements above and had the opportunity to ask questions. I understand that statements and consent for the influenza vaccine.

Employee Signature: _____ **Date** ____/____/_____

Nurse Administering Vaccine: _____ **Date** ____/____/_____

FLU VACCINE (TYPE OF INFLUENZA): _____

Site of Injection: LA _____ RA _____

Manufacturer/Lot#: _____ Expiration Date: _____

Declination: ☐

I, _____ understand that I may be at risk for acquiring influenza and transmitting the virus to others. I have been given the opportunity to be vaccinated with the inactivated influenza vaccine; However, I declined the influenza vaccinations at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring influenza, a serious illness and of transmitting the virus to others. I understand that I can change my mind later and accept vaccination if the vaccine is still available. If required by local or state regulation, **I will be required to wear a surgical mask at work while in patient care areas for the duration of the flu season**. If the Centers for Disease Control (CDC) reports regional or widespread flu activity in the state in which I work, my supervisor will alert me, and I will be required to wear a surgical mask for close patient contract (within five feet) until the activity diminishes. The surgical mask will be supplied by the location at no cost to me.

Employee Signature: _____ **Date** _____

Witness Name: _____ **Witness Signature** _____ **Date** _____