DECLINATION FORM FOR SEASONAL INFLUENZA VACCINE

Name(printed):_____ 3-4 ID_____ Last 4 SSN:_____
First, Middle, Last (as it appearson W4)

DateofBirth:_____

Facility:_____ Department: _____

This facility has recommended that I receive influenza vaccination in order to protect myself and the patients I serve.

IDO NOT WANT A FLUSHOT.

Iacknowledge that I amawareofthefollowingfacts:

- Influenza isaseriousrespiratorydisease; on average, 36,000 Americans die every year from influenza-relatedcauses.
- Influenza virusmaybeshedforupto 24 hours before symptoms begin, increasing the risk of transmissiontoothers.
- Some peoplewithinfluenzahaveno symptoms, increasing the risk of transmission to others.
- Influenza viruschangesoften,making annual vaccination necessary. Immunity following vaccination is strongestfor2to6months.[InCalifornia, influenza usually begins circulating in early January and continues throughFebruaryorMarch.]
- I understandthattheinfluenzavaccine cannot transmit influenza and it does not prevent all disease.
- I have declinedtoreceivetheinfluenza vaccine for the 2019-2020 season. I acknowledge that influenza vaccinationisrecommended by the Centers for Disease Control and Prevention for all healthcare workersinordertoprevent infection from and transmission of influenza and its complications, includingdeath,topatients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form. I am declining due to the following reasons (check all that apply):

- ☐ I believe I will get influenza if I get the vaccine.
- ☐ I do not like needles.
- ☐ My philosophical or religious beliefs prohibit vaccination.
- ☐ I have an allergy or medical contraindication to receiving the vaccine.
- ☐ Other reason – please tell us. _____

- I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.
- I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.
- I have read and fully understand the information on this declination form.

_____ _____
Signature Date

Place Employee Info label here, if desired