

As a healthcare professional, you may have exposure to the influenza virus. You can either consent to or decline the vaccination but you must complete this form to assure that if you remain unvaccinated, you have personally declined the vaccine and agree to wear a N95 respirator or surgical mask for the duration of your shift starting September 1st, if required. **Please read the influenza information and complete this form with signature and date.**

CONSENT. I have been informed about and offered the opportunity to receive the influenza vaccine. I understand that it is my responsibility to schedule to have the vaccination with either my healthcare provider or with the healthcare facility prior to any direct contact with patients. As with any medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effect from the vaccine. The vaccine takes about two weeks to reach maximum protection. Therefore, I will not be fully protected from catching the flu until that time. I accept the offer and provide the following information: **(If the vaccine has already been obtained please attach documentation)**

Date of Vaccination: _____ Site of Administration: _____
 Type of Vaccine: _____ Dose: _____
 Manufacturer & Lot #: _____ Reactions, if any: _____
 Name of Person Administering the Vaccine: _____ Ph#: _____
 Signature : _____ Title: _____

DECLINE. In declining the influenza vaccination for non-medical reasons, I am aware that I cannot get the influenza disease from the influenza vaccine. I can be infected by the influenza virus but not feel ill for 24-48 hours before symptoms appear, and I can pass the virus to vulnerable patients who are at risk of complications or death from influenza. I can also pass the virus to my family, friends and co-workers. Influenza strains change every year and an immunization received in prior years does not usually provide immunity to this year's strain of influenza. Despite these facts, I am choosing to decline the influenza vaccination right now because:

- _____ I have a medical contraindication. **Please check one:**
- Allergy to eggs, chickens or chicken feathers
 - Guillain-Barre Syndrome or a persistent neurological illness
 - Severe allergy to other vaccine component
 - Other: _____

Based on the requirements of your assignment location or facility:

- 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 may be required to wear a N95 respirator or surgical mask for the duration of my shift beginning September 1st. Failure to wear a N95 respirator or surgical mask during duty will result in disciplinary action, up to and including termination.
- I understand that I may change my mind at any time and accept the influenza vaccination, if the vaccine is available.
- I understand that if I decline the vaccine AND refuse to wear a N95 respirator or surgical mask, I am voluntarily resigning my position.

I have read and fully understand the information on this form.

Fax to: 1-800-709-4610

Healthcare Professional Name (Print)

Healthcare Professional Signature **Date**