Documentation of Influenza Vaccination

I understand that immunization against influenza in healthcare workers is an important patient safety issue and supported by centers for disease control and prevention ("CDC"), the society of health epidemiologists of America, the American medical association, and the American academy of pediatrics, the infectious disease society of America, and the joint commission, my employer. Strongly recommends that I receive annual influenza

I understand that I must be absolutely truthful regarding my attestation about receiving the influenza vaccination

I confirm that I received the influenza vaccine from a Non-occupational health services provider (example, Primary care physician, outside provider, Health department, a pharmacy, etc.).

1. I already have been immunized of-site this season.
   ____ YES
   ____No
2. Employee First Name:_____
3. Employee Last Name:_____
4. Employee ID Number: (if Applicable):_____
5. Date vaccination received:_____/_____/_____
6. Job Title:_____
7. Employee signature:_____ Date: _____/_____/_____

Declination of Influenza Vaccination

My employer or affiliated health facilities, has recommended that I receive influenza vaccination to protect the patient I serve.
I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract i influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including

  *All patients in this healthcare facility
  *My coworkers
  *My Family
  *My community

  Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:
  _____

  _____

  _____

  I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.
  I have read and fully understand the information on this declination form.
  Name: _____ Date: _____
  Signature: _____
  Depatment:_____