

Declination of Influenza Vaccination

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

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect our patients from influenza disease, its complications and death.
- If I contract influenza, I will be contagious for 24–48 hours before influenza symptoms appear, and I can spread influenza disease to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
- I understand that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine 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 the following:
 - my patients and other patients in this healthcare setting
 - my co-workers
 - my family
 - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reason(s):

- Severe allergy to a component of the flu vaccine- *Requires a note from your physician, see below***
- Severe Allergy to eggs- *Requires a note from your physician, see below***
- History of Guillain-Barre syndrome- *Requires a note from your physician, see below***
- The declination from my physician is already on file at the COMP Center. *(If it is already on file you don't need to obtain another copy. Please submit this form to employee health and that is all you need to do for this year.)***
- **I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is available.**
- **I understand I must have a valid reason for declining the vaccine.**
- ***I will need a physician's statement, on letterhead or prescription pad, and physician signature to validate my reason for declination.***

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

Signature: _____ Date: _____

Name (print): _____

Department: _____ ID #: _____

The Employee Health fax number is 858-4571.
Please Employee Health if you have any questions about this declination.
Employee Health phone number is 450-2225

References:

- CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm
- www.immunize.org/catg.d/p4068.pdf, Item #P4068 (8/10)
- Technical content reviewed by the Centers for Disease Control and Prevention, August 2010
- Immunization Action Coalition, 1573 Selby Ave., St. Paul, MN 55104, (651) 647-9009, www.immunize.org, www.vaccineinformation.org