Influenza Vaccination Consent or Declination Form

I understand it is my responsibility to obtain the influenza vaccine if required at clients I am scheduling at through Progressive Nursing Staffers. I understand if I decline the vaccine this will impact my scheduling ability at clients that require annual influenza vaccine.

Printed Name: _____ Last 4 SSN:_____

□ **CONSENT**: I have been informed and understand the benefits and risk associated with the influenza vaccine. I also understand it is not possible to predict all the possible side effects/complications associated with the vaccine.

Date of Vaccination: _____Site of Administration_____

Type of Vaccine:_____ Dose:_____

Manufacturer & Lot #:_____ Reactions, if any:_____

Name of Person Administering the Vaccine:_____ Title:_____
Provider Address:_____ Phone #:_____

Provider Signature:_____ Date_____

□ **DECLINE:** In declining for non-medical reasons and despite the below facts I am choosing to decline getting the influenza vaccination at this time because: I have a medical contraindication (check all that apply), and will supply support documentation.

- □ Allergy to eggs, chickens or chicken feathers
- □ Guillain-Barre Syndrome or persistent neurological illness
- □ Severe allergy to other vaccine component
- □ Other:_____

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 all healthcare workers to protect patients from influenza disease, its complications, and death.
- □ If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding the virus 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 I will have to use a N95 respirator or surgical mask during my shift per facility policy.
- □ 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 my patients and other patients in this healthcare setting my coworkers, my family, and my community

I have read and fully understand and agree to the above that apply.

Signature: _____ Date:_____

Provider Signature: _____ Date:_____