Summit Healthcare

Influenza Vaccine Declination Form

I acknowledge that I am aware of the following facts:
Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.

- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent all disease.

I have declined to receive the influenza vaccine for medical or religious reasons. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all health care employees to prevent infection from and transmission of influenza and its complications, including death, to patients/residents/clients, my co-workers, my family and my community.

I decline the offer of vaccination for the following reason:

☐ I have a medical contraindication to receiving the vaccine:

Healthcare provider Name & signature of validating the medical contraindication (required):

PROVIDER NAME: _____ Date: _____

Signature: _____

☐ My religious beliefs prohibit vaccination. Please explain:

_____

☐ **OTHER: MUST EXPLAIN REASON:**

_____

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

Employee: _____ Department: _____
(Print Name)

Signature: _____ Date: _____