DECLINATION FORM FOR SEASONAL INFLUENZA VACCINE

Name (printed):_____ 3-4 ID_____ Last 4 SSN:_____
First, Middle, Last (as it appears on W4)

Date of Birth:_____

Facility: _____ Department: _____

This facility has recommended that I receive influenza vaccination in order to protect myself and the patients I serve.

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. [In California, influenza usually begins circulating in early January and continues through February or March.]
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the 2019-2020 season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form. I am declining due to the following reasons (check all that apply):

- ☐ I believe I will get influenza if I get the vaccine.
- ☐ I do not like needles.
- ☐ My philosophical or religious beliefs prohibit vaccination.
- ☐ I have an allergy or medical contraindication to receiving the vaccine.
- ☐ Other reason – please tell us. _____

- 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 will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.
- I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.
- I have read and fully understand the information on this declination form.

_____ _____
Signature Date

OU Medicine

Place Employee Info label here, if desired