

## Declination of Influenza Vaccination

My employer or affiliated health facility, \_\_\_\_\_, has recommended that I receive influenza vaccination in order 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 prevent influenza disease and its complications, including 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 infection to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild, 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 cannot get the influenza disease from the influenza vaccine.
- The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:
  - patients in this healthcare setting
  - my coworkers
  - my family
  - my community

I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (print): \_\_\_\_\_

Department: \_\_\_\_\_