Influenza Declination

Employee Name: ______________________________ Date: ________________

My employer or affiliated health facility has recommended that I receive the influenza vaccination to protect the patients that I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to my patients.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza 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 all my patients, my coworkers, my family, and my community.

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: ____
____

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

____________________________________	____________________________
Employee Name	Date
____________________________________	____________________________
Employee Signature	Date
____________________________________	____________________________
Witness Signature	Date