UNIVERSITY HEALTH SERVICES INFLUENZA CONSENT/DECLINATION FORM 2010/2011

It is recommended that all employees and students of Thomas Jefferson University/Hospitals receive the influenza vaccination in order to protect the patients we serve. University Health Services personnel have provided the vaccine information sheet dated August 10, 2010 and I have been given the chance to ask questions about influenza, this vaccine, and the risks and benefits of vaccination. **I am aware that the policy for the 2011/2012 influenza season will require the influenza vaccine for all employees, physicians, students and volunteers.**

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 understand that I **cannot** get the influenza disease from the influenza vaccine.
- Vaccination is recommended for any woman who will be pregnant or breastfeeding during flu season. Vaccination can occur in any trimester.
- 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

☐ **Yes, I would like to receive the flu vaccine to protect patients, family members and myself.**

☐ **Yes, I have received the flu vaccine at another office:**

Location: _____ **Date of Vaccination:** _____

☐ **No, I have read the above information but do not wish to receive the influenza vaccine. I decline vaccination for the following reason(s):**

___I have a medical contraindication. Please check one:
- ___Allergy to eggs or egg products (shock-like reaction)
- ___Severe allergy to a vaccine component
- ___Guillain-Barre Syndrome within 6 weeks of previous vaccination
- ___ Other: (please specify) _____

___I decline for non-medical reasons. Please check one:
- ___I am afraid of shots
- ___Fear of side effects
- ___Fear of getting flu from the vaccine
- ___Other (please tell us)_____

Last Name **First Name:**

Signature_____DOB:_____ Date_____

Department_____ Extension_____

Please Circle: Employee Attending Housestaff Volunteer Student (Program) _____

For Office Use Only

Latex allergy **__yes** **__no**

Date VIS (8/10/10) and Vaccine Given_____ Manufacturer/Lot number/Expiration Date_____

Site of Injection ___LT IM ___RT IM ___FLUMIST Given By:_____

Pregnant___ Breast feeding___ Egg Allergy___ Tolerated___Yes___No