

Annual Influenza Vaccine Consent & Administration Form

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| **NAME** | **EMPLOYEE NUMBER** |
| **CAMPUS*** MCSS ☐LBMC ☐MCWHLB ☐OCMC ☐SMC ☐MCMF
 | **DEPARTMENT** |
| **CATEGORY*** Employee ☐LIP/Physician ☐Volunteer ☐Student/Resident ☐Contractor ☐Registry ☐Other
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Declination of Influenza Vaccination

# I HAVE ALREADY HAD THE FLU VACCINE THIS SEASON AND HAVE ATTACHED PROOF OF VACCINATION

# I DO NOT WANT THE FLU VACCINE:

 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 every year.
	+ Up to 30% of people with influenza have no symptoms, allowing transmission to others. Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
	+ I understand that flu vaccine cannot transmit influenza. It does not, however, prevent all disease.
	+ I acknowledge that influenza vaccination is recommended by the CDC for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, my patients, my coworkers, my family, and my community.

# Despite these facts, I choose to decline vaccination for the following reasons:

* + - I have a medical contraindication to receiving the vaccine, please describe:
		- Other, please describe:

# I CHOOSE TO DECLINE vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I understand that I am required to wear a mask for the duration of the flu season while on campus.

**Signature: Date:**

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