

SEASONAL INFLUENZA VACCINATION CONSENT OR DECLINE 2021-2022
COMPLETE ALL PERSONAL INFORMATION BELOW.

MUST PRINT NAME: First _____ MI _____ Last _____ **OPID:** _____

DATE OF BIRTH: ____/____/____ **SEX ASSIGNED AT BIRTH:** Male Female

STATUS: Team Member Student Consultant Agency Volunteer Medical Staff Other _____

Division: _____ **Campus :** _____

Department: _____ **Manager:** _____

Performs direct patient care: YES NO

EMAIL ADDRESS: _____ (For Acknowledgement Receipt of your Vaccination Selection for records)

COMPLETE THE CONSENT OR DECLINE BELOW: You will automatically be Declined if you answer YES to any of the following questions:

1. Have you ever had a severe allergic reaction to chicken eggs? YES NO
 2. Have you had a severe reaction to an influenza vaccination or other vaccinations in the past? YES NO
 3. Have you ever developed Guillain-Barre syndrome following influenza vaccination? YES NO
- If Yes to Question 1, a vaccine that does not include eggs may be available.**

CONSENT FOR VACCINATION – I verify that I have read the current CDC Vaccination Information Statement and consent to receive the influenza vaccination. I also understand that, while people with minor illnesses, such as a cold, may be vaccinated, I should not receive the influenza vaccination if I am moderately or severely ill and should wait until I have recovered.

I have already received the influenza vaccination this year elsewhere (You will be required to provide documentation of vaccination to **Human Resource, the Employee Clinic, or fax to XXX-XXX-XXXX** for the information to be recorded, please also visit your **Campus Human Resources or Employee Clinic** to receive a Flu Shot sticker).

- Pharmacy Centra Care Employee Clinic Personal Physician
 Grocery Store Community Outreach Other _____

Declination of Vaccine*
Please Choose an Exemption for your declination

Medical Exemption

I request a medical exception from influenza vaccination due to one of the following contraindications below:

- History of previous allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine.
- History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine.

Religious / Strongly Held Personal Belief Exemption

Because the required influenza vaccination conflicts with my sincerely held religious and/or strongly held personal beliefs and practices, I decline the influenza vaccination at this time.

I attest that, by submitting this exemption, I am declining the flu vaccination. I understand that I am required and agree to wear an appropriate personal protective equipment (PPE) mask at all times while on duty at any AdventHealth place of business during the influenza season. When working in an office or cubicle space, I understand that I am permitted to remove my mask when I am not within six (6)-feet of another individual..

***Influenza vaccination can be received at any time after declining.**

 PRINT NAME SIGNATURE DATE

Administration Site (circle one): Left / Right Deltoid **Dosage: 0.5 ml** **Lot #:** _____

Manufacturer: _____ **Expiration Date:** _____

 ADMINISTERED BY (PRINT NAME) SIGNATURE DATE

Place influenza vaccine label here