

## Declination of Influenza Vaccination

My employer or affiliated health facility, \_\_\_\_\_, has recommended that I receive influenza vaccination 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 protect our patients from influenza disease, its complications, and 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 disease to patients in this facility.
- ◆ If I become infected with influenza, even when my symptoms are mild or non-existent, 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 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
  - my patients and other patients in this healthcare setting
  - my coworkers
  - my family
  - 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 influenza vaccination, if vaccine is available.

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

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

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

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

Reference: CDC. Prevention and Control of Seasonal Influenza with Vaccines—  
Recommendations of ACIP at [www.cdc.gov/flu/professionals/acip/index.htm](http://www.cdc.gov/flu/professionals/acip/index.htm)