North Central Health Care
Person centered. Outcome focused.

Influenza Vaccination Employee Statement

I am aware of the influenza policy and have had a chance to have my questions answered about influenza vaccination. I understand the benefits and risks of the vaccine, and by signing below I **agree** to have the influenza vaccine for the 2020 influenza season.

_____ _____ _____

Print Name: Date of Birth Today's Date

_____ _____

Signature Program

_____ _____

Parent/Guardian signature (if under age 18) Today's Date

Influenza Vaccination Administration

Already vaccinated ☐ I have already been vaccinated against influenza this season. Please provide proof.	Provider Name:_____ Date of Vaccination: _____/_____/_____ **Please provide proof of vaccination**		
Flu vaccination screening questions:	1) Are you sick today?	☐ Yes	☐ No
	2) Do you have any life threatening allergies to a component of the influenza vaccine? Please List:	☐ Yes	☐ No
	3) Have you had a life-threatening reaction to an influenza vaccine in the past?	☐ Yes	☐ No
	4) Have you ever had Guillain-Barre syndrome?	☐ Yes	☐ No
	5) Is this the first time you have received an influenza vaccine	☐ Yes	☐ No

Administrative Use Only		
Name of Vaccination: Influenza Vaccine		
Date administered/VIS given:____/____/_____	Date of VIS: 8/15/2019	
Vaccine: Fluarix Quadrivalent 2020/2021 Formula		
Lot #: LE79N	Mfg: GlaxoSmithKline	**Site:** **( ) Left Deltoid** **( ) Right Deltoid**
Dose: 0.5 ml.	Exp. Date: 6/30/2021	**Name and title of vaccine administrator:** _____

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Declination of Influenza Vaccination

North Central Health Care has recommended that I receive influenza vaccination in order to protect myself and 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 from flu-related illness.
  - 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 the severe illness to others.
  - I understand that the strains of the virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
  - I cannot get the influenza disease from the influenza vaccine.

The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:

- Residents/patients in this healthcare setting
- My coworkers
- My family
- My community

Despite these facts, I am choosing to decline influenza vaccination right now.

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

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

Signature:_____ Date:_____

Name (print): _____

Department: _____

Resource: http://www.health.state.mn.us/divs/idepc/diseases/flu/vaccine/vaxhcw/