AdventHealth

SEASONAL INFLUENZA VACCINATION CONSENT OR DECLINE 2020-2021

COMPLETE ALL PERSONAL INFORMATION BELOW.

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

DATE OF BIRTH: _____/_____/_____ **GENDER:** ☐ Male ☐ Female

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

Division: _____ **Campus:** _____

Department/Cost Center: _____ **Manager:** _____

Performs direct patient care: ☐YES ☐NO

EMAIL ADDRESS: _____

(For Acknowledgement Receipt of your Vaccination Selection for your 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 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 407-303-0693 for the information to be recorded, please also visit your Campus Human Resources or Employee Clinic to receive a Flu Shot sticker).

☐ Retail 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. Please provide and attach a detailed narrative that describes the event.

☐ **Religious / Strongly Held Personal Reason 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 a surgical mask at all times as defined in policy CWHR 260-Influenza Vaccinations, and when within six (6) feet of a patient, during the influenza season.

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

PRINT NAME _____ SIGNATURE _____ DATE _____

For Administering Healthcare Professional ONLY

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