

Employee ID:

Grid for Employee ID

Employee Health Services
2006-2007 Influenza Vaccination



Please complete all questions on this form - Black or Blue Ink Only

Please check one: Employee Volunteer Medical Staff

Cost Center Grid

First Name (please print clearly; all CAPS)

Grid for First Name

Last Name (please print clearly; all CAPS)

Grid for Last Name

Acceptance of 2006-2007 Influenza Vaccination

YES NO

- I have reviewed the 2006-2007 flu vaccine information sheet and had my questions answered.
1. Are you allergic to eggs or egg products?
2. Are you allergic to thimerosal (a preservative) other than contact lens sensitivity?
3. Have you ever had Guillian-Barre Syndrome within 6 weeks of taking a flu shot?
4. Have you ever had an anaphylactic reaction to the influenza vaccine?
5. Are you allergic to latex?
6. Did you receive a flu shot last year?

I accept to receive the 2006-2007 Influenza Vaccination.

Signature: [Signature Line]

Date: [Date Grid]

Declination of 2006-2007 Influenza Vaccination

My employer or affiliated health facility, St. Joseph Hospital, has recommended that I receive influenza vaccination in order 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 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 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 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:
- patients in this healthcare setting
- my coworkers
- my family
- my community

I understand that I may 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.

I decline to receive the 2006-2007 Influenza Vaccination.

Signature: [Signature Line]

Date: [Date Grid]

2006-2007 Influenza Vaccine

For EHS use only

Avery Address Label 5160

Site: Left Deltoid Right Deltoid

Signature: [Signature Line], RN

Date: [Date Grid]

