



2014-2015
INFLUENZA (FLU) VACCINE DECLINATION

PRINT NAME

Employee#

PRINT DEPARTMENT/UNIT

Check One: [ ] Associate [ ] Physician [ ] Volunteer [ ] Other (i.e. contractor, student, etc.)

CHOC Children's has given me the opportunity to receive the Influenza vaccine at no charge to me.

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 226,000 persons in the United States each year.
A different influenza vaccine is recommended each year because the strains of the virus that cause influenza can change.
I cannot get the influenza disease from the influenza vaccine.
I understand that by declining this vaccine I continue to be at increased risk of acquiring influenza and can spread it to others, even though I do not have any symptoms.
The consequences of 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 co-workers
\* My family
\* My community

I understand that I may change my mind at any time and accept the Influenza vaccination, if the vaccine is available and it is during the season for which the CDC recommends administration of the influenza vaccine.

Reason for declining Influenza (flu) Vaccine: (PLEASE CHECK ONE)

- [ ] Medical exemption (submit documentation to Associate Health)
[ ] Religious exemption (submit documentation to Associate Health)
[ ] Other (please specify): \_\_\_\_\_

I have read and fully understand the information on this declination form. I understand I will wear a surgical mask at all times while on any CHOC Children's grounds during the entire Influenza season as per IC Policy # 604. Non-compliance may be cause for immediate disciplinary action up to and including termination.

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