Declination of Influenza Vaccination

My employer or affiliated health facility, *Sumner Regional Medical Center*, 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 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
 - o my co-workers
 - o my family
 - o my community

Despite these facts, I am choosing to decline vaccination right now for one of the following reasons and *understand that I must provide a physician's statement supporting that reason to Employee Health:*

O Allergy to eggs or other components of the of O History of Guillain-Barre' after receiving vac O Personal reasons	<u> </u>
I understand that if I choose not to receive wear a mask when involved in direct patier influenza season, October through March. at any time and accept influenza vaccination, in	nt contact for the duration of the I understand that I can change my mind
I had read and fully understand the information	n on this declination form.
Name (print):	DOB:
Signature:	Date:
Dept.:	