AdventHealth

SEASONAL INFLUENZA VACCINATION CONSENT OR DECLINE 2021-2022
COMPLETE ALL PERSONAL INFORMATION BELOW.

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

DATE OF BIRTH: _____/_____/_____ **SEX ASSIGNED AT BIRTH:** ☐ Male ☐ Female

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

Division: _____ **Campus:** _____

Department: _____ **Manager:** _____

Performs direct patient care: ☐YES ☐NO

EMAIL ADDRESS: _____ **(For Acknowledgement Receipt of your Vaccination Selection for 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 also understand that, while people with minor illnesses, such as a cold, may be vaccinated, I should not receive the influenza vaccination if I am moderately or severely ill and should wait until I have recovered.

☐ **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 XXX-XXX-XXXX for the information to be recorded, please also visit your Campus Human Resources or Employee Clinic to receive a Flu Shot sticker).

☐ 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.

☐ **Religious / Strongly Held Personal Belief 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 an appropriate personal protective equipment (PPE) mask at all times while on duty at any AdventHealth place of business during the influenza season. When working in an office or cubicle space, I understand that I am permitted to remove my mask when I am not within six (6)-feet of another individual..

***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