Influenza Immunization Declination

PH BROOKVILLE
PH CLEARFIELD
PH CONNELLSVILLE
PH CORPORATE
PH DUBOIS
PH ELK
PH HUNTINGDON
PH MON VALLEY
PH TYRONE
PHCNI
HELPMATES
PH PHYSICIAN NETWORK
JEFFERSON MANOR
WRC/MCKINNLEY
PINECREST MANOR

My employer or affiliated health facility, Penn Highlands Healthcare, 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 thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- 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 all patients in this healthcare facility, my coworkers, my family, and my community.

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

_____ I had an influenza vaccination already this year and authorize release of this information from my provider. **I HAVE COMPLETED AN AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (OVER)** so documentation of my vaccination can be released to Employee Health**.**
Date vaccinated: _________________ Provider: ________________________________

_____ I had **SEVERE (anaphylaxis, life threatening)** allergic reaction after getting a flu shot (RARE)

_____ I have **SEVERE (anaphylaxis, life threatening)** allergy to eggs (RARE)

_____ I have a history of **Guillain-Barré** syndrome

_____ I am currently **MODERATELY OR SEVERELY** ill. **Describe:**

____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I understand that I am required to wear a surgical mask during influenza season (November 1 – March 31) anytime that I am within 6 feet of another person (patient, co-worker, and visitor).

I have read and fully understand the information on this declination form.

Signature: _______________________________ DOB:______________Date: ____________

Name (print): ______________________________________ Employee #: ______________