Creighton UNIVERSITY

Declination of the Seasonal Influenza Vaccination

Date: _____ **Department:** _____

Employee's Name _____ **Date of Birth:** _____

The Centers for Disease Control has recommended that I receive influenza vaccination in order to protect myself and 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 226,000 persons in the United States each year.
- Influenza vaccination is recommended, by CDC, 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. 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 co-workers
  - my family
  - my community

I am choosing to decline influenza vaccination for the following reason:

☐ I have a medical contraindication (documentation attached).
- According to the Guide to Contraindications to Vaccinations published by the CDC

☐ I have already received the seasonal influenza vaccine for the 2009/2010 season from another health care provider (documentation attached).

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

Signature: _____ Print Name: _____

Witness Signature _____ Print Name: _____