Updated 8/4/2023

Declination Form For Seasonal Influenza Vaccine

Name (printed):________________________________ EEID#:______________________ DOB:________________

McLaren Facility Location: ________________________ Please Check One: ☐ Employee ☐ Non-Employed Provider ☐ Contractor ☐ Volunteer/Student

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McLaren Health Care has recommended that I receive influenza vaccination, in order to protect myself and the patients I serve. I am eligible to receive a flu vaccination through my local employee health department free of charge.

I am making an informed decision to decline influenza vaccination this year.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline the seasonal influenza vaccination at this time. I may change my mind and accept vaccination later if vaccine is available. I have read and fully understand the information on this declination form. I am declining due to the following reasons (check all that apply):

☐ I believe I will get influenza if I get the vaccine.
☐ I do not like needles.
☐ My philosophical or religious beliefs prohibit vaccination.
☐ I have an allergy or medical contraindication to receiving the vaccine.
☐ Other reason **(please provide explanation here):** ____

I understand the consequences of my declining to be vaccinated could endanger my health and the health of those with whom I contact including: my patients, my co-workers, my family, and my community.
I understand I may be asked to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas when influenza season peaks.

I understand that I may change my mind at any time and accept influenza vaccination if vaccine is available. I have read and fully understand the information on this declination form.

______________________________________ ____________________

Signature **Date Signed**