Name of Healthcare Facility

Address where vaccine is given

INFLUENZA VACCINATION CONSENT/DECLINATION RECORD

Consent

The influenza virus vaccine is recommended for elderly and high-risk patients, their household contacts, healthcare personnel, and anyone who wishes to reduce the chance of catching influenza.

I **DO NOT** have any of the conditions listed below:

1. Serious allergy to eggs.
2. Serious reaction to previous flu vaccine.
3. History of Guillain-Barre syndrome.
4. Moderate or severe illness.

I understand that as with any medication, serious problems, even death can occur. The risks from the vaccine are much smaller than the risks from the disease. Almost all people who get influenza vaccine have no serious problems from it. If mild or moderate problems occur, they are fever, aches, or soreness/redness/swelling where the shot was given.

I understand that Name of Healthcare Facility or any persons acting as their agent are not responsible for any adverse reactions that I may sustain.

I have been offered information on influenza vaccination. I consent to the administration of the influenza virus vaccine.

***Name*_____ *Dept.* _____**

***Date* ___/____/_____ *Manufacturer*_____ *Lot #* _____**

***Influenza virus vaccine 0.5cc given in* _____ *deltoid. By* _____ *Title*_____**

***Publication date of Vaccine Information Sheet (VIS)* _____ *Date VIS given:* ___/__/___**

Declination

I understand that I am at risk for exposure to influenza and may be a risk for developing influenza infection. I have been given the opportunity to be vaccinated with the influenza vaccine at Name of Healthcare Facility. However, I decline the influenza vaccine at this time. I understand that by declining this vaccine, I may continue to be at risk for influenza infection and I may also put patients and my other contacts at risk for influenza. Should I want the vaccine in the near future, I should notify my physician or the Employee Health nurse.

_____ _____ _____

Signature of person declining to receive the vaccine ***Date*** ***Dept***

_____ _____

Witness ***Date***

Please check all that apply if you do not plan on getting the flu vaccine:

___ I think that the flu shot can give me the flu
___ I don't like needles
___ Moderate to severe illness today
___ Allergy to eggs
___ I don't ever get the flu
___ History of Guillain Barre syndrome
___Other (specify) _____

___ I don't think the flu shot works
___ I don't think I will come down with with the flu
___ I don't feel the flu will cause serious harm to people
___ Serious reaction to flu vaccine

Flu Vaccine Sign In Sheet

Date	Name	Position	Department