 DEPARTMENT OF NURSING

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INFLUENZA VACCINE CONSENT/DECLINATION

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| I have had a flu shot as documented by the information below: Clinic where vaccinated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date vaccinated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer and lot number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose and Site\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I decline the vaccination: please complete the following section |
| You may submit a receipt or proof of vaccination on another form if that is what is provided.  |

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| **Influenza Vaccine Declination** **Written declination is required by California Senate Bill No. 739 as of 2007** I acknowledge that I have been made aware of the following facts: √ Influenza is a serious disease that kills an average 36,000 Americans each year √ Influenza virus may shed for up to 48 hours before symptoms appear, allowing unknown transmission to others √ 30% of individuals may have no symptoms, allowing unknown transmission to others √ Flu virus changes often and requires annual vaccination √ Flu vaccine cannot transmit disease but does not prevent all disease √ I decline to receive the vaccine for the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ season √ Influenza vaccine is recommended by the CDC for all healthcare workers to prevent disease transmission √ Spread of influenza may cause harm/death to my fellow healthcare workers, family members and patients **Knowing these facts I choose not to be vaccinated at this time and understand the information presented in this form. I understand I will be required to wear a mask at all times per facility requirements.** Print name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I decline the vaccination for the following reason(s). Check all that apply. \_\_\_\_\_\_\_\_ I am allergic to the vaccine \_\_\_\_\_\_\_\_ My philosophical or spiritual beliefs prohibit vaccination \_\_\_\_\_\_\_\_ I have a medical contraindication to receiving the vaccine \_\_\_\_\_\_\_\_Other reasons for declining you wish to discuss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |