 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |