SONOMA STATE UNIVERSITY | NURSING

Name: ____ Date: _______________

Program: ____

Influenza Vaccine Declination

I acknowledge that I have been made aware of the following facts:

- Influenza is a serious disease that kills many 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____