

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:

- | | |
|--|---|
| <input type="checkbox"/> I think that the flu shot can give me the flu | <input type="checkbox"/> I don't think the flu shot works |
| <input type="checkbox"/> I don't like needles | <input type="checkbox"/> I don't think I will come down with the flu |
| <input type="checkbox"/> Moderate to severe illness today | <input type="checkbox"/> I don't feel the flu will cause serious harm to people |
| <input type="checkbox"/> Allergy to eggs | <input type="checkbox"/> Serious reaction to flu vaccine |
| <input type="checkbox"/> I don't ever get the flu | |
| <input type="checkbox"/> History of Guillain Barre syndrome | |
| <input type="checkbox"/> Other (specify) _____ | |

