

Influenza Vaccine Consent/Declination
2014-2015

Please take this form to the In-Patient Nurses Station and they will be happy to assist you with your vaccine. Thank you!

Annual Vaccine is available between Oct. & March of each year)

PLEASE RETURN THIS COMPLETED FORM TO HUMAN RESOURCES AS PROOF OF VACCINATION

Print Name:

| Screening Questions for Contraindications to the Inactivated Influenza Vaccine | | NO | YES | If "yes" |
|---|--|-----------|------------|--|
| 1 | Have you had a fever of 100°F or greater during the last 24 hours? | | | Check with your physician before getting vaccine. |
| 2 | Have you ever had a reaction to a previous immunization such as fever over 105°F, paralysis, convulsions, total collapse or shock? | | | Check with your physician before getting vaccine. |
| 3 | Are you being treated with medications such as cortisone, prednisone, chemotherapy, or radiation that lowers the body's resistance to infection? | | | Check with your physician before getting vaccine. |
| 4 | Are you allergic to eggs, thimerosal (mercury derivative, or latex? | | | Check with your physician before getting vaccine. People with severe reactions to eggs should not get the vaccine. |
| 5 | Have you ever had Guillain-Barre Syndrome? | | | Check with your physician before getting vaccine. |
| 6 | Are you pregnant? | | | You MUST receive the preservative-free vaccine. |

| CONSENT | Vaccine Information | Info |
|---|--|--|
| <input type="checkbox"/> By signing, I acknowledge I have received education about the effectiveness of influenza vaccination as well as the adverse events and I am <u>consenting</u> to receive the Seasonal Influenza Vaccination. Signature: _____ Date: _____ | Manufacturer: _____ Lot #: _____ Exp Date: _____ | <input type="checkbox"/> Employee Dept. _____ <input type="checkbox"/> Volunteer <input type="checkbox"/> Physician/Nurse Practitioner <input type="checkbox"/> Other _____ |
| DECLINE | Administration Information | |
| <input type="checkbox"/> By signing, I acknowledge I have been offered this vaccine and informed of its benefits I have also been made aware as an employee of BRMC I will have to wear a mask during flu season Oct thru March while in the facility and I have chosen to <u>decline</u> Vaccination. Signature: _____ Date: _____ | Vaccine Information Sheet Given: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Vaccination Given: _____ Site Vaccination Given: _____ _____ <i>Signature of Nurse Administering Injection</i> <i>Date</i> | |

IF YOU HAVE ALREADY HAD A FLU SHOT THIS SEASON, PLEASE PROVIDE COPY OF YOUR SHOT RECORD!