

UAB HOSPITAL

Employee Health

Consent/ Declination Form: 2015-2016 QUADRIVALENT INACTIVATED INFLUENZA VACCINE

A/California/7/2009 (H1N1)
A/Switzerland/9715293/2013 (H3N2)
B/Phuket/3073/2013-like virus.
B/Brisbane/60/2008

The UAB Medicine has recommended that I receive influenza vaccination in order to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to prevent influenza disease and its complications, including death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza infection to patients.
- I understand that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I cannot get influenza disease from influenza vaccine.
- The consequences of my refusing to be vaccinated could endanger my health and the health of my patients, coworkers, and family.

Despite these facts, I choose to decline influenza vaccination at this time. Below please check your reason for declining the influenza vaccine.

Serious egg allergy is no longer a reason for declination as an egg free vaccine will be made available

(THIS IS NOT A LIVE VIRUS VACCINE SO IT CANNOT CAUSE THE FLU)

Yes	No	Medical Contraindications				
		1. Severe allergic reaction (e.g. anaphylaxis) after a previous vaccine				
		dose or to a vaccine component, including egg protein; OR				
		2. History of Guillain - Barre' syndrome within 6 weeks after a				
		previous influenza vaccination.				
Vaccination Status of HCW: Check all that applies.						
	I consent to receive the Influenza vaccine.					
	I authorize designa	ated staff of the hospital to administer the vaccine.				
П						
	I am not able to receive the vaccination due to contraindication (s) above.					
		enza vaccine due to personal reasons				
	lf de	eclined for personal reasons, check all that apply:				
	Fear of needles	s/injections				
	Fear of side effects					
	Perceived ineffectiveness of vaccine					
	Religious or ph	ilosophical objections				
	Concern for tra	nsmitting vaccine virus to contacts				
	Other (Specify)	:				
	I have already had	my influenza vaccination this year.				
	Date vaccinated:	Location:				
	_					
	This is the first inf	luenza vaccination I have ever taken.				



Print Name Legibly And Complete All Of The Following:

Last Name (As It Appears In Oracle)		First Name (As It Appears In Oracle)		MI	Signature
Blazer ID	Employee II	O or SS# S NOT On Your Badge)	Job Title	Unit	Manager/Supervisor
			☐Right Deltoid ☐Left Deltoid		☐ VIS Given
Manufacturer	\Lot # \Exp. Da	te	Site		
Please Check	: One:	-	Signature of Em Person Adminis	ployee Health RN\ tering Vaccine	Today's Date
Includes GM		ellows, LLC	-	•	g in the hospital. (GME
			<u>:RS</u> (Non-Hospita s, Advanced Pra	l employees) ctice Nurses, NPs and	PAs.
	ENTS/ VOLUN aid HCP, Boar				
Medical Stud	lent	Nursin	g Student	□ Volunteer	SRC
] Pharmacy St	udent 🗌 Tra	inees	PSYCH]	
Student fron Institution (F	n Non-UAB Please Indicate	e)	Other	(Please Indicate	
] <u>UAHSF</u> (NOT	Physicians/ Po	ost-Doc. Fel	lows/ Advanced	Practice Nurses/PA'	s) (NON-TKC)
TKC (UAHSF)	□ тко	C (LLC)			
HEALTH SYST	<u>ГЕМ</u>				
Health Syste	m Hospital	Health	System Non-Ho	ospital	
CONTRACT DE					
CONTRACT PE	RSONNEL				
_		NOT Advanc	ed Practice Nurs	ses)	
_	ency Nurses (N			ses)	
Registry/ Ag	ency Nurses (N	rvice Work		ses)	

^{***}Thank you for taking the time to complete the entire form. Your name will be kept confidential but numbers will be transmitted to the National Healthcare Safety Network (NHSN) and Health and Human Services (HHS as mandated. ***