

Consent/Declination Form: 2016-2017 QUADRIVALENT INACTIVATED INFLUENZA VACCINE

A/ (H1N1)

A/ (H3N2)

B/Florida/04/2006 B (Yamagata)

B/Brisbane/60/2008 (B Victoria)

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
<input type="checkbox"/>	<input type="checkbox"/>	1. Severe allergic reaction (e.g. anaphylaxis) after a previous vaccine dose or to a vaccine component, including egg protein; OR
<input type="checkbox"/>	<input type="checkbox"/>	2. History of Guillain - Barre' syndrome within 6 weeks after a previous influenza vaccination.
Vaccination Status of HCW: Check all that applies.		
<input type="checkbox"/>	I consent to receive the Influenza vaccine. I authorize designated staff of the hospital to administer the vaccine.	
<input type="checkbox"/>	I am not able to receive the vaccination due to contraindication (s) above.	
<input type="checkbox"/>	I decline the influenza vaccine due to personal reasons If declined for personal reasons, check all that apply: <input type="checkbox"/> Fear of needles/injections <input type="checkbox"/> Fear of side effects <input type="checkbox"/> Perceived ineffectiveness of vaccine <input type="checkbox"/> Religious or philosophical objections <input type="checkbox"/> Concern for transmitting vaccine virus to contacts <input type="checkbox"/> Other (Specify): _____	
<input type="checkbox"/>	I have already had my influenza vaccination this year. Date vaccinated: _____ Location: _____	
<input type="checkbox"/>	This is the first influenza vaccination I have ever taken.	

****Please Complete the Information on the Back of This Page****



Print Name Legibly And Complete All Of The Following:

_____	_____	_____	_____
Last Name	First Name	MI	Signature
(As It Appears In Oracle)	(As It Appears In Oracle)		
_____	_____	_____	_____
Date of Birth	SS#	Job Title	Unit
	(Employee ID # IS NOT On Your Badge)		
_____		<input type="checkbox"/> Right Deltoid	<input type="checkbox"/> Left Deltoid
Manufacturer\Lot # \Exp. Date		Site	<input type="checkbox"/> VIS Given
		_____	_____
		Signature of Employee Health RN\	Today's Date
		Person Administering Vaccine	

Please Check One:

HOSPITAL EMPLOYEE (Employee on Hospital/ Facility Payroll)
Includes GME Residents, Fellows, LLC and Health System employees working in the hospital. (GME RESIDENTS ARE HOSPITAL EMPLOYEES).

LICENSED INDEPENDENT PRACTITIONERS (Non-Hospital employees)
Includes Attendings, Post-Doc. Fellows, Advanced Practice Nurses, NPs and PAs.

ADULT STUDENTS/ VOLUNTEERS (18+)/ TRAINEES
Includes unpaid HCP, Board Members and Clergy.

Medical Student Nursing Student Volunteer SRC

Dental Student Pharmacy Student Trainees PSYCH

Student from Non-UAB Other (Please Indicate COA
Institution (Please Indicate)

UAHSF (NOT Physicians/ Post-Doc. Fellows/ Advanced Practice Nurses/ PA's) (NON-TKC)

TKC (UAHSF) TKC (LLC)

HEALTH SYSTEM

Health System Hospital Health System Non-Hospital

CONTRACT PERSONNEL

Registry/ Agency Nurses (NOT Advanced Practice Nurses)

Contract Environmental Service Workers

Contract Maintenance Workers

OTHER CATEGORIES NOT LISTED: Please Indicate: _____

***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. ***