UAB MEDICINE

UAB HOSPITAL

Employee Health

Consent/ Declination Form: 2014-2015 QUADRIVALENT INACTIVATED INFLUENZA VACCINE
A/California/7/2009 (H1N1)
A/Texas/50/2012 (H3N2)
B/Massachusetts/2/2012
B/Brisbane/60/2008

(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 designated staff of the hospital to administer the vaccine.
☐		I am not able to receive the vaccination due to contraindication (s) above.
☐		I decline the influenza vaccine due to personal reasons If declined for personal reasons, check all that apply: __ Fear of needles/injections __ Fear of side effects __ Perceived ineffectiveness of vaccine __ Religious or philosophical objections __ Concern for transmitting vaccine virus to contacts __ Other (Specify): _____
☐		I have already had my influenza vaccination this year. Date vaccinated: _____ Location:_____
☐		This is the first influenza 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 ID or SS#** (Employee ID # IS NOT On Your Badge) | **Job Title** | **Unit** | **Manager/Supervisor**

_____ ☐ Right Deltoid ☐ Left Deltoid ☐ VIS Given

Manufacturer\Lot # \Exp. Date | **Site**

_____ _____

Signature of Employee Health RN\ Person Administering Vaccine | **Today's Date**

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

OVER

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**

☐ **Dental Student** ☐ **Pharmacy Student** ☐ **Trainees**

☐ **Student from Non-UAB Institution (Please Indicate)** ☐ **Other (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. *****