RIDEOUT HEALTH

2020-21

CONSENT/DECLINATION FOR THE INFLUENZA VACCINE

CONSENT

I, the undersigned, hereby verify that I have authorized the Rideout Health Group to administer influenza vaccine to me.

ALL VACCINES THIS SEASON ARE PRESERVATIVE FREE.

1. I understand that the following are *contraindications for receiving the vaccine.*
    a. A severe reaction, sensitivity or history of anaphylactic reaction (hives, swelling of mouth and throat, difficulty breathing, hypotension, or anaphylactic shock) subsequent to receiving influenza vaccine
    b. Current acute respiratory or other active infection or illness
2. I have read the Influenza Vaccine Information Statement, dated 8/7/2015. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine.
3. To my knowledge I have none of the above contraindications.

____**VOLUNTEER** ____**TRAVELER** ____**CONTRACTED** ____**MED STAFF** ____**EMPLOYEE**

Name (print): _____ **Emp#**_____

Signature: _____ **Date:** _____

Dose: 0.5ml **Site:** Deltoid R L **Lot #:** _____ **Exp Date:** _____

Date: _____ **Given by:** _____

DECLINATION

I acknowledge that I am aware of the following facts:

1. Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
2. Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
3. Up to 30% of people with influenza have no symptoms, allowing transmission to others.
4. Flu virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. In CA, influenza usually arrives around January through February or March.
5. I understand that flu vaccine cannot transmit influenza. It does not, however, prevent all disease.

I have declined to receive the influenza vaccine for the 2015-2016 season. I acknowledge that influenza vaccination is recommended by the CDC for all healthcare workers to prevent infection from and transmission of the influenza and its complications, including death, to patients, my coworkers, my family, and my community.

I understand that by declining the influenza vaccine I will be required to wear a mask at all times when I am in a Rideout Health facility where patient care is provided. This requirement will be enforced from November 1, 2015–March 31, 2016. I understand that failure to adhere to these guidelines will result in discipline up to and including termination.

I wish to decline due to (please check one):

- ☐ I do not like needles
- ☐ Adverse reaction in the past
- ☐ Already received vaccine this season* *(checking this box REQUIRES proof of vaccination)*
- ☐ Philosophical or religious beliefs
- ☐ Personal preference

____**VOLUNTEER** ____**TRAVELER** ____**CONTRACTED** ____**MED STAFF** ____**EMPLOYEE**

Name (print): _____ **Emp#**_____

Signature: _____ **Date:** _____