Jackson HEALTH SYSTEM
Miracles made daily.

OCCUPATIONAL HEALTH SERVICES
INFLUENZA VACCINATION PROGRAM

Complete all questions on this form even if you are NOT receiving the vaccine

PLEASE PRINT ----- *NAME, BIRTH DATE AND EMPLOYEE ID ARE REQUIRED FIELDS

☐ JHS Employee ☐ (Non-JHS) Licensed Independent Practitioner (Attending Physician, MD, PA, ARNP, RN, LPN) ☐ Non-JHS Employee (Student, Volunteer, Guest) ☐ Contract Worker Only

*Last Name	*First Name	Job Title	Cost Code

*JHS Badge#	SSN#	*Birthday (month/day/yr.)	Division	Work Phone

HEALTH CARE WORKER: PLEASE COMPLETE THE FOLLOWING SELF ASSESSMENT:

Read the Vaccine Information Sheet (VIS). The following are medical reasons why you should not take the vaccine. Pregnancy is not a contraindication. Even if you answer yes to any of the following, you may still be able to take the vaccine to be protected. If you're not sure contact your doctor or call the Health Office at 786-466-8381 **or** email HealthOffice@jhsmiami.org.

Have you had one of the medical contraindication listed below?	
☐ Yes ☐ No	A severe (life threatening) allergic reaction to any component of the vaccine, including egg protein, gelatin, antibiotics and/or after previous dose of any influenza vaccine.
☐ Yes ☐ No	Guillain-Barré Syndrome (a neurological disease) 6 weeks after taking a flu vaccine
☐ Yes ☐ No	Moderate to severe illness with or without fever.

☐ I want the Influenza Vaccine. Signature: _____ Date: _____

☐ I already had the flu shot for 2014-2015 flu season. (Attach documentation)

Place where vaccinated: _____ Date Vaccinated: _____

Signature: _____ Date: _____

TO BE COMPLETED BY JHS OCCUPATIONAL HEALTH SERVICES OR PEER TO PEER STAFF

Vaccine Information: ☐ Influenza Vaccine

Dose: 0.5 ML Route: IM ☐ Left Deltoid ☐ Right Deltoid

Place Manufacturer Sticker Here

Manufacturer _____ Lot# _____ Exp. Date _____

Administered by (Print): _____ JHS Badge #: _____ Date Administered _____

Department: _____

OHS STAFF USE ONLY

Date in STIX: _____ Initials: _____

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OCCUPATIONAL HEALTH SERVICES

INFLUENZA VACCINATION PROGRAM

Declination of Seasonal Influenza Vaccination

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Jackson Health System has recommended that I receive influenza vaccination 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 persons in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect our patients from influenza diseases, its complications and 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 disease to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
- 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 understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threating consequences to my health and the health of those with whom I have contact, including:
  - ➢ My patients and other patients in this healthcare setting
  - ➢ My family
  - ➢ My coworkers
  - ➢ My community

☐ Despite these facts, I am choosing to decline the vaccine right now for the following reasons:

O **Medical contraindication**	O **Fear of getting flu**	O **Fear of shots**
O **I don't think the vaccine works**	O **Spiritual/Religious Belief**	O **Fear of side effects**

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is available.
I have read and fully understand the information on this declination form.

Signature: _____ Date: _____