

**Declination of Influenza Vaccination *2016-2017***

My employer San Mateo Medical Center has recommended that I receive influenza vaccination to protect myself, the patient I serve and my family.

I am choosing to decline influenza vaccination right now for the following reasons:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I am aware of the following facts:

* Influenza is a serious respiratory disease that kills thousands of people in the United States every year.
* Influenza vaccination is recommended for me and all other healthcare workers to protect this facility’s patients from influenza, its complications, and possible death.
* If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear from my respiratory tract. My shedding the virus can spread influenza to patients, co-workers, and visitors in this facility as well as to my own family.
* I understand that the strains of virus that cause influenza infection can change every year and my immunity declines over time. H1N1 (which is an animal virus) requires annual re-vaccination because immunity from the vaccine lasts only one flu season. This is why CDC now recommends flu vaccination annually for all persons older than 6 months of age.
* I understand that I cannot get influenza from the influenza vaccine.
* I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

***I have read and fully understand the information on this declination form.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee/ATKS number (if applies): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department Org # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please Check One:***

**□** SMMC Employee **□** Contracted Licensed Provider (MD, PA, NP)

**□** Volunteer/Student/Intern **□** Other: Contracted Personnel or County Staff (Public Health, Registry etc)