TRI-CITY Medical Center
EMPLOYEE HEALTH SERVICES
4002 Vista Way, Oceanside, CA 92056
Phone (760) 940-7270 – Fax (760) 940-4005
Office Hours Monday – Friday · 7:30 a.m. – 4:00 p.m.

DECLINATION OR RECEIVED ELSEWHERE
INFLUENZA VACCINATION 2017 – 2018

Last Name: _____ First Name: _____ Department: _____

- ❑ **Employee ID Number:_____**
- ❑ **Volunteer ID Number:_____ Jr Volunteer ID Number:_____ Date of Birth_____**
- ❑ **Physicians/LIP's**
- ❑ **Contractor/Company:_____**
- ❑ **Student/School:_____ Other:_____**

I DECLINE THE FLU VACCINE

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 49,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. In California, influenza usually begins circulating in early October and continues through February or March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all influenza diseases.
- I have declined to receive the influenza vaccine for the 2017-2018 season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.
- I understand that it is requirement/policy that I wear a "surgical mask" while working in the hospital during the Flu season, if I decline the flu vaccine.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.
I **decline vaccination** for the following reason(s). Please check all that apply.

☐ I have a severe allergic reaction from a previous vaccine dose

☐ I have a serious allergy to eggs or other vaccine component(s)

☐ I have had Guillain-Barre syndrome within 6 weeks after Influenza vaccine

☐ My philosophical or religious beliefs prohibit vaccination.

☐ Other reason – please tell us: _____

Signature _____ ***Date*** _____

I HAVE RECEIVED THE FLU VACCINE ELSEWHERE

I have already received the 2016-2017 flu shot. You will be counted as vaccinated

Where vaccinated _____

Date vaccinated _____ **(approximate is OK)**

Signature _____ ***Date Signed*** _____