Employee Statement of Permission for Influenza Vaccine

I, _____ , (DOB)_____an employee of the facility has been offered the influenza vaccine by my employer.

It is my understanding that receipt of this vaccine is not a mandatory condition of employment and I do have thee right to refuse the vaccine.

Risks: I understand that I should not receive this vaccine if I am in my first trimester of pregnancy or if I am allergic to the vaccine, eggs, or chicken. I have been instructed that because of this vaccine, I may experience side effects such as, but not limited to, soreness at the vaccination site, body aches, systemic reactions (i.e., fever, fatigue, muscle aches). Rare side effects such as, but not limited to, hives, allergic asthma, anaphylaxis.

Benefits: The flu vaccine is beneficial in limiting and/or preventing types of influenza specified yearly by the manufacturers of the vaccine. Influenza may result in severe debilitation, hospitalization, and/or death depending on the employee's overall health status. The vaccine may help with limiting lost time at work, spreading the infection to family and the elderly population you care for.

The influenza vaccine is an inactivated vaccine that is given with a needle, usually in the arm. This vaccine will not cause the flu. Coincidental respiratory disease unrelated to the vaccine can occur. The flu vaccine is approved for use in people older than 6 months, including healthy people and people with chronic medical conditions.

I have had the opportunity to review the VIS. This statement of permission or declination will serve as my release of any liability or wrongdoing by the facility and its employees in the administration of the influenza vaccine.

Signature: _____Date Accepted: _____

Guardian Signature: _____Date Accepted: _____
(If employee is under 18 years of age)

Signature: _____Date Declined: _____

Guardian Signature: _____Date Declined: _____
(If employee is under 18 years of age)

VACCINE ADMINISTRATION:
Vaccine: _____ Lot#: _____ Exp Date: _____

Temp: _____ Site of Administration: _____

Nurse/Pharmacist signature: _____ Date: _____