

CAREGIVER HEALTH SERVICES

PLEASE RETURN COMPLETED FORM TO CAREGIVER (EMPLOYEE) HEALTH SERVICES

Seasonal Influenza Declination Form 2024-2025

Providence and its family of organizations offers the influenza vaccine free of charge to caregivers, volunteers, students, employed & non-employed providers, and contracted employees in accordance with the annual CDC recommendations. By being vaccinated, you are protecting yourself, your patients, your family, and the community.

NAME: _____ DOB: _____ EMPLOYEE ID# _____

CAMPUS/SITE: _____ DEPT: _____ PHONE: _____

IF **NOT** EMPLOYED BY PROVIDENCE, CHECK ONE: Licensed Independent Practitioner Volunteer Contractor **Student** Other**I DO NOT WANT A FLU VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:**

- *Influenza is a serious respiratory disease that millions of people get every year. Hundreds of thousands are hospitalized, and thousands to tens of thousands die from flu-related causes.*
- *Influenza vaccination is recommended for me and all healthcare workers to protect our patients from influenza disease, its complications, and death.*
- *Persons infected with influenza virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, some of whom may be at higher risk for complications from influenza.*
- *Healthcare personnel influenza vaccination has reduced deaths among nursing home patients and elderly hospitalized patients.*
- *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 impact of my declining the vaccine could include life-threatening 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 coworkers, my family, and my community.*
- *Side effects of the vaccine are almost universally mild and of short duration.*
- *I understand the vaccine offered to me through Caregiver Health Services is preservative and latex free.*
- *I understand that I can change my mind and accept the vaccination at any time during the campaign, usually September through March.*
- *I understand I must follow any masking requirements in my ministry or region and commit to doing so.*

Resources for future reference:

<https://www.cdc.gov/nhsn/pdfs/hps-manual/vaccination/hps-flu-vaccine-protocol-508.pdf><https://www.cdc.gov/flu/prevent/keyfacts.htm>**I am declining the flu vaccine because of:** My Licensed Independent Practitioner-documented allergy or medical contraindication to the components of the vaccine My religious beliefs, including my sincerely held ethical or moral beliefs

By typing your name on the line below, you certify that (i) you are the individual completing the form; (ii) all information entered on this form is true and accurate to the best of your knowledge; (iii) you agree with all terms and conditions as listed on this form; and (iv) you consent to typing your name as the means of providing your signature electronically and that such electronic signature is valid.

Signature: _____

Date: _____