HURLEY MEDICAL CENTER

Infection Control

Influenza Vaccination Form

Please fill out form below and give to your cost center manager or Infection Control

Name (**Please Print Legibly**)_____

Signature _____

Date_____ **Department**_____ **Cost Center**_____

Privacy ID_____ **School or agency if applicable**_____

CIRCLE ONE: **Employee** (on HMC's payroll), **Resident physician, Nurse Practitioner or PA** (on HMC's payroll)
LIP (Attending physician, Advance Practice Nurse, PA (not on HMC's payroll)
Adult Student/Trainees and Volunteers, Affiliate organization_____
Other Contracted Personnel (example HPMS employees), Affiliate organization_____

CHECK ONE**:** ☐ **Accepted** (complete Section 1) ☐ **Declined** (complete Section 2)

SECTION 1: **CONSENT AUTHORITY TO ADMINISTER FLUVIRIN INFLUENZA VIRUS VACCINE**

I have had the opportunity to ask any questions concerning the vaccine and I understand that the consequences of the use of this vaccine cannot always be predicted in any one particular individual. It is possible that I may not react favorably to the Fluvirin® inactivated influenza vaccine. With full knowledge of this and having been offered the CDC's Influenza Vaccine Information sheet, ***I consent*** to the administration of this vaccine and I assume all risk for possible harmful results, releasing the Medical Center and its personnel from liability for the injection of this vaccine. I also assume the responsibility in reporting to the personnel in charge of the administration of this vaccine any and all unusual symptoms and feelings immediately, should any arise while receiving or after receiving this vaccine.

A checkmark below indicates that I have one of the following conditions:

____ Have you received the flu vaccine before
____ Allergy to eggs
____ Guillain-Barre Syndrome or any other neurological condition (s)
____ Respiratory or other active infection/illness

Survey: ***Work Setting:*** _____ Direct Patient Care (clinical) _____ Non-Patient Care (non-clinical)

VIS form dated: 8/7/2015 provided to employee on the above date. Lot # _____ vaccine utilized_____

R : L . _____ Dose 0.5ML
Site (deltoid) Signature of Vaccine Administrator

If you have "Taken Elsewhere" (Flu Vaccination not taken at Hurley Medical Center)
Location where you received your vaccination: _____ Date vaccination was given elsewhere: _____
If documentation of vaccination is available please attach to this form.

SECTION 2: **DECLINATION**

Flu Shot Declination: Reason(s) I am declining: (Please check all that apply)

I have a medical condition that prevents me from being vaccinated:
- **I am allergic to eggs**
- **A history Guillan-Barré Syndrome within 6 weeks after a previous influenza vaccination**

Other conditions/reasons for declining: (Please check all that apply)
- **Religious exemption**
- **I just don't want the vaccine**
- **I don't have time to get vaccinated or it is too inconvenient**
- **I don't think the vaccine works.**
- **I don't think I will get the flu.**
- **I am fearful of getting sick or of other side effects.**
- **I am pregnant (CDC recommends flu shots for pregnant women)**

ALL FORMS MUST BE RETURNED TO INFECTION CONTROL
INFECTION CONTROL FAX 810-262-7268/PHONE 810-262-9513