Jersey Community Hospital
400 Maple Summit Road
Jerseyville, IL 62052
(618) 498-6402

DECLINATION OF INFLUENZA VACCINATION

My employer Jersey Community Hospital has recommended that I received influenza vaccination in order to protect myself and the patients I serve.

1. _____ (initial) I have read the "Influenza Vaccine Information Statement, I have had the opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine.

Employee Name (print): _____ Department: _____

Location where vaccinated: _____ Date: _____

2. **I acknowledge that I am aware of the following facts**:
   - Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
   - Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
   - Up to 30% of people with influenza have no symptoms, allowing transmission to others.
   - Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
   - I understand that influenza vaccine cannot transmit influenza. It does not, however, prevent all disease.
   - *I have declined to receive the influenza vaccine for the **2016 season.** I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all health care employees to prevent infection from and transmission of influenza and its complications, including death, to patients/residents/clients, my co-workers, my family and my community*.

3. I acknowledge that if I choose to sign the declination of influenza vaccination I will be required to wear a mask while at work during the high flu season.

4. Knowing the fact set forth above, 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.

5. **I decline the offer of vaccination for the following reasons** (please initial all that apply):

   _____ My philosophical or religious beliefs prohibit vaccination.
   _____ I have a medical contraindication to receiving the vaccine: reason_____
   _____ Other reason _____
   _____ I do not wish to say why I decline.

   Print name: _____ Department: _____

   Signature: _____ Date: _____

/mme 8/13, 9/14, 10/14, 9/15, 9/16