INFLUENZA (FLU) VACCINATION HISTORY OR DECLINATION

ATC OFFICE INSTRUCTION: This record is to be maintained in the Employee's Medical File

The American College of Physicians (ACP) and the Centers for Disease Control and Prevention (CDC) recommend healthcare workers with direct patient care duties receive an annual influenza vaccine. Transmission of influenza from health care workers to patients and from patients to healthcare workers has been documented.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that can result in hospitalization and death.
- Influenza vaccination is recommended for all healthcare workers with direct patient contact to prevent influenza disease and its complications.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients.
- I understand that the strains of virus that cause influenza infection can change almost every year. This is the reason why a different influenza vaccine is recommended annually.
- I cannot get influenza disease from receiving an influenza vaccine.
- The consequences of my refusing to be vaccinated could potentially endanger my health and the health of my patients, co-workers, and family.

☐ I have been informed by ATC HEALTHCARE SERVICES, of the facilities at which I can receive the influenza vaccine, if available. Influenza vaccination may be available at local clinics, local pharmacies (e.g., CVS, Rite Aid), public health departments, occupational health clinics, local hospital occupational health clinics, and physician offices. I will report to ATC in a timely manner, the name of the facility and date I received the vaccination which is to be documented on the Influenza Vaccination Documentation Form or acceptable alternative provided by the vaccine administering facility.

☐ **Declination Statement:** I certify by my signature below that I understand that due to my occupational exposure to potentially infected materials that I may be at risk for acquiring influenza. I have been provided with information on where to obtain influenza vaccination, however, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Influenza. If in the future, I continue to have occupational exposure to influenza and I want to be vaccinated, ATC will refer me to a proper source so that I can receive the vaccination, if available.

PRINT NAME: _____ **TITLE:**_____

EMPLOYEE SIGNATURE:_____

DATE: _____

INFLUENZA VACCINATION DOCUMENTATION FORM

NAME OF PERSON RECEIVING VACCINE: _____

DATE OF VACCINATION:_____

LOT#:_____ EXPIRATION DATE:_____

ADMINISTERED BY:_____

TITLE:_____