

**Infection control news (cont.)**

**Sample declination of influenza vaccination**

Influenza vaccination guidelines by the CDC and JCAHO encourage facilities to offer immunizations to staff and to obtain signed forms from those who decline vaccination. Use this form, adapted from the Immunization Action Coalition to document employees' declinations of influenza vaccination. A PDF version of the form is available at [www.immunize.org/catg.d/p4068.pdf](http://www.immunize.org/catg.d/p4068.pdf).

My employer or affiliated health facility, \_\_\_\_\_, has recommended that I receive influenza vaccination in order to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to prevent influenza disease and its complications, including death.
- If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding of the virus can spread influenza infection to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
- 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 cannot get the influenza disease from the influenza vaccine.
- The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including patients in this healthcare setting, my coworkers, my family, and my community.
- Despite these facts, I am choosing to decline influenza vaccination right now.
- I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.

I have read and fully understand the information on this declination form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (print): \_\_\_\_\_

Department: \_\_\_\_\_

Source: Immunization Action Coalition, St. Paul, MN. Reprinted with permission.