

Assessment of Annual Influenza Vaccination

Mandatory per California Law effective 7-1-07

The Centers for Disease Control has recommended that I receive influenza vaccination in order to protect myself and 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, by CDC, 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. Shedding 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
 - my community

I am aware of these facts and have already been vaccinated this season (2010-2011)

Despite these facts, I am choosing not to be vaccinated at this time. 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 assessment form.

I am not getting the vaccination at this time due to the following reasons: (check all that apply)

- I am allergic to components of the vaccine
- I don't believe in vaccines.
- I won't take the vaccine because of side effects.
- I don't believe it is important. I never get the Flu.
- I have had Guillen Barre or other medical problems that preclude me from receiving the vaccine.
- I got severe Flu symptoms from the Flu vaccine and won't get it again.
- Other (specify) _____

Provider Printed Name: _____

Date ____/____/20____

Provider's Signature: _____

Return Completed Form to Medical Staff Services

Fax to (916) 733-8380

Or reply on-line at http://www.suttermedicalcenter.org/forourphysicians/pdf/flu vaccine_form.pdf