

**MOSES CONE HEALTH SYSTEM
INFLUENZA VACCINE CONSENT/DECLINATION FORM
2008-2009 SEASON**

This form MUST be completed by every employee and returned to Employee Health

Influenza vaccine is strongly recommended for healthcare workers, not only to protect themselves, but also to reduce the chance of spreading influenza in the workplace and community. Influenza infection can lead to serious complications and can be fatal, especially in elderly or sick persons, including those who are hospitalized. In the U.S., approximately 200,000 people are hospitalized and 36,000 people die from influenza each year. FORTUNATELY, the influenza vaccine is highly effective in PREVENTING infection. When infection occurs despite vaccination, it is usually milder. Moses Cone Health System is committed to the health and well-being of employees, employee's families and patients, and considers influenza vaccination of all MCHS employees a high PATIENT SAFETY priority. The influenza vaccine is provided to MCHS employees at no cost.

PLEASE HELP PREVENT THE TRANSMISSION OF INFLUENZA BY RECEIVING THE ANNUAL INFLUENZA VACCINATION.

PRINT First Name _____ MI _____ Last Name _____

Employee Medical Staff Contract/Temporary Volunteer

Campus: AP ASB BHC LB MC RCC WH WL Other: _____

Department/Unit: _____ First 3 digits of SS# _____ - XX - X XXX

Answer the Following Questions	YES	NO
1. Have you ever had a severe allergic reaction to chicken eggs?		
2. Have you had a severe reaction to an influenza vaccination or other vaccinations in the past? (facial swelling, difficulty breathing)		
3. Do you have an allergy to any preservative used in vaccines?		
4. Have you ever developed Guillian-Barre syndrome following influenza vaccination?		
5. Do you have a fever (over 100 ° F) or feel ill today? Please return in one week.		

COMPLETE ONE OF THE THREE SECTIONS BELOW

CONSENT FOR VACCINE – I verify that I have read the current CDC Vaccine Information Statement and indicate my willingness to receive the influenza vaccine.

Signature: _____ **Date:** _____

Employee Health/Vaccine Coordinator Use Only	
Vaccine Manufacturer Sanofi Pasteur Inc Fluzone® Lot #U2753AA Exp: 30Jun09	Injection Site: Deltoid L / R Other: _____
Administered by: _____	Date: _____

I received the influenza vaccination on (date) _____ from (PRINT) _____.

Signature: _____ **Date:** _____

DECLINATION OF VACCINE – I am eligible to receive the influenza vaccine but do not want to take it. I understand that by refusing the vaccine I may be putting my FAMILY, FRIENDS and PATIENTS at risk of getting influenza. I am aware that hospitalized patients are at increased risk of getting serious complications following influenza infection. If, in the future, I want to be vaccinated with the influenza vaccine, I can.

CHECK YOUR REASON(S) for not receiving the influenza vaccine. ____ See Question # ____ above

____ Dislike of needles ____ Concern of side effects ____ Don't think vaccines work ____ Never get flu

____ Don't believe in vaccines ____ Fear of getting influenza from vaccine Other: _____

Signature: _____ **Date:** _____