

Inland Empire Clinical Placement Consortium for Nursing

Student Declination of Annual Influenza Vaccination

The Joint Commission Infection Control Standard IC.4.15 emphasizes that transmission of influenza from health care providers can create serious health care problems. The most successful measure to prevent health care-associated transmission of influenza is healthcare worker vaccination. The Centers for Disease Control and Prevention (CDC) has recommended annual influenza vaccinations for all healthcare workers since 1981.

As of July 2007, in accordance with IC.4.15, hospitals are required to evaluate healthcare worker vaccination rates and reasons for non-participation in the Annual Influenza Vaccination Program. Please read the information below and indicate the reason you have chosen not to receive the vaccination.

I understand that due to my occupational exposure, I may be at risk for acquiring influenza infection. In addition, I may spread influenza to my patients, other healthcare workers and my family, even if I do not have any symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications.

I have received education about the effectiveness of influenza vaccination as well as the adverse effects. I have also been given the opportunity to be vaccinated with influenza vaccine. However, I decline influenza vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring influenza, potentially resulting in transmission to my patients. If in the future I want to be vaccinated with influenza vaccine, I can receive the vaccine.

I have chosen not to receive the vaccine for the following reason (healthcare provider documentation MUST BE attached):

- _____ 1. *I have already been vaccinated for the current year.*
- _____ 2. *I am or may be pregnant and cannot take the multi-dose flu vaccination offered.*
- _____ 3. *I am allergic to eggs, chicken and / or latex.*
- _____ 4. *I have a medical condition which precludes me from receiving the vaccination (i.e. Hemophilia, Guillian Barre or any active neurologic disease)*
- _____ 5. *Other:* _____

Student Name: _____ Date: _____
PLEASE PRINT

Student Signature: _____ School _____

NOTE: Some clinical facilities have additional requirements that must be met.