archcare
The Continuing Care Community of the Archdiocese of New York

FLU VACCINATION CONSENT/DECLINATION FORM - 2022/23

Employee Name: _____ **Date of Birth:** _____

Title: _____ **Department:** _____

Signature: _____ **Date:** _____

TO BE COMPLETED BY INDIVIDUAL RECEIVING THE FLU VACCINE:

I, _____, consent to the administration of the flu vaccine.
(Employee's Name – First Last)

I am aware that some people experience pain at the site of injection and some may experience fever.

I testify that I have none of the conditions listed below:

1. A severe allergy to eggs.
2. A severe reaction to a flu shot in the past.
3. A history of Gullian-Barre Syndrome (GBS) in the 6 weeks after getting a flu shot.

TO BE COMPLETED BY INDIVIDUAL DECLINING TO RECEIVE THE FLU VACCINE:

I, _____, decline to receive the flu vaccine.
(Employee's Name – First Last)

I acknowledge that I have been advised of the following:

- Patients/Residents are at special risk for complications of the flu, including death.
- The Flu vaccination is strongly recommended for me and all other healthcare workers to help prevent spreading flu to patient/residents, coworkers, family and others.
- If I contract the flu, even a mild case, I will be contagious for 24-48 hours before I get sick. Debilitated and high risk patients/residents with whom I may come in contact could develop a severe infection even if my infection is mild.
- I understand that the flu virus changes almost every year, and that is why an annual flu shot is strongly recommended.
- I cannot get the flu from the flu vaccine because it does not contain a live flu virus.
- I have received education about the flu vaccine.
- I understand that by choosing not to receive the flu vaccination, I must wear a flu mask in designated areas where patients/residents may be present, during the period of time in which the flu is deemed prevalent.

Please note that individuals who decline to receive the flu vaccine because they have been vaccinated elsewhere for the 2022/2023 flu season must provide written proof of vaccination from their doctor to the Human Resources Office.

THIS SECTION TO BE COMPLETED BY PERSON ADMINISTERING VACCINE:

Today's Date:		**Site of Injection:**	
Location Providing Vaccine:		**Lot #:**	
Name of Person Administering Vaccine:		**Expiration Date:**	

PLEASE RETURN COMPLETED FORM TO THE HUMAN RESOURCES OFFICE.