Seasonal Influenza Vaccination Downtime Form

I have read or have had explained to me the information about influenza and influenza vaccine. I have had an opportunity to discuss the benefits and risks of influenza vaccine with a healthcare provider of my choice before coming here today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine.

Print full name*

Home address* **City*** **State*** **ZIP Code***

Email address* **Phone number*** **3/4 ID or Last 4 of SSN*** **Date of birth***

I have read/or been offered the CDC Flu Vaccination Statement (VIS) ☐ Yes

Consent to receive vaccine? ☐ Consent to receive vaccine ☐ Decline ☐ Already Received Vaccine

Is the person receiving the vaccine allergic to any component of the influenza vaccine? ☐ Yes ☐ No

Does the person receiving the vaccine have a latex allergy? ☐ Yes ☐ No

Has the person receiving the vaccine had a fever of at least 100.4 in the last 24 hours? ☐ Yes ☐ No

Has the person receiving the vaccine received a stem cell or bone marrow transplant within the last 4 months?
☐ Yes ☐ No

Does the person receiving the vaccine have a history of Guillain-Barré syndrome within 6 weeks of receiving an influence vaccine? ☐ Yes ☐ No

Has the person receiving the vaccine ever experienced an anaphylactic reaction to the influenza vaccine?
☐ Yes ☐ No

Signature of person receiving vaccine **Date**

***Required**

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DO NOT WRITE IN THIS SPACE – NURSE USE ONLY

3/4 ID of vaccinator*:_____ Lot number*:_____ Expiration Date*:_____

Vaccine manufacturer*:

- ☐ Sanofi Pasteur
- ☐ GlaxoSmithKline (GSK)
- ☐ Seqirus
- ☐ AstraZeneca

Vaccine Product*:

- ☐ Fluzone Trivalent Pre-filled Syringe
- ☐ Fluzone High-Dose Trivalent (65+) Pre-filled Syringe
- ☐ Flucelvax Trivalent
- ☐ Afluria Trivalent Pre-filled Syringe
- ☐ Flublock Triv Pre-filled Syringe (9+only)
- ☐ FluAd Trivalent (65+0nly)

Location where vaccine was administered*:

- ☐ HCA Hospital
- ☐ HCA CareNow/MDNow
- ☐ HCA Physician Practice
- ☐ None of the above

Market Name*:_____ **Facility Name*:**_____

Vaccine location*:

- ☐ Left deltoid
- ☐ Right deltoid

Badge sticker provided?

- ☐ YES
- ☐ NO

_____ _____ _____

Signature of person completing form | Date | Time

***Required**

Seasonal Influenza Vaccination Downtime Form

2025-2026 Seasonal Influenza Vaccine Declination

Print full name*:_____

Email address*:_____ 3/4 ID*:_____ Date of birth*:_____

Vaccine is for*:

- ☐ Employee
- ☐ Volunteer
- ☐ Student/Trainee
- ☐ Licensed Independent Practitioner (Physician)
- ☐ Licensed Independent Contractor (Other)
- ☐ Dependent Healthcare Professional

I AM DECLINING THE FLU SHOT.

This facility recommended I receive the influenza vaccination in order to protect myself and the patients I serve. I decline the vaccination at this time, while acknowledging my awareness of the following facts:

- Influenza is a serious respiratory disease. On average, over 60,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
    - In California, influenza usually begins circulating in early January and continues through March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I decline to receive the influenza vaccine for the 2025-2026 season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

REQUIRED - CHECK ALL THAT APPLY: I am declining due to the following reason(s):

- ☐ I have a medical condition
- ☐ My philosophical or religious beliefs prohibit vaccination
- ☐ Other reason (describe):_____

Declaration of Declination

I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.

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

This form must be entered into the Enterprise Health System once completed.

***Required**