Influenza Vaccination Consent/Declination

Last: _____ First: _____

DOB: _____

To the best of your knowledge, does/has the person ever had the following:

Received an influenza vaccine?	◯ No ◯ Yes
An allergy to latex?	◯ No ◯ Yes
Sensitivity to any components of the influenza vaccine?	◯ No ◯ Yes
Adverse Reaction to the influenza vaccine or other vaccinations?	◯ No ◯ Yes
History of Guillain-Barre Syndrome?	◯ No ◯ Yes

☐ I Consent to receiving the Influenza Vaccination

I (resident/decision maker) have received the Vaccine Information Statement for the Inactivated Influenza vaccine. I (resident/decision maker) am aware that if I (resident/decision maker) would like additional information or have questions, I (resident/decision maker) am able to contact the Infection Preventionist Nurse, other appointed facility nurse, or my (resident) healthcare provider. I (resident/decision maker) believe I (resident/decision maker) understand the benefits and risks of the Influenza Vaccine, and request that the Influenza Vaccine be given to me, or the person named above, for whom I am authorized to make this request.

☐ I am choosing to Decline the Influenza Vaccination

I (resident/decision maker) have been advised that I resident) should receive the influenza vaccine. I have reviewed the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I (resident/decision maker) have had the opportunity to discuss the statement and have my (resident/decision maker) questions answered by a healthcare provider. I (resident/decision maker) am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me resident) and all other residents and staff to protect this facility's other residents and staff from influenza, its complications, and death.
- If I (resident) contract influenza, I (resident) can shed the virus for 24 hours before influenza symptoms appear. My (resident) shedding the virus can spread influenza to other residents and staff in this facility and families that may visit during this time.
- If I (resident) become infected with influenza, I (resident) can spread severe illness to others even when my (resident) symptoms are mild or non-existent.
- I (resident/decision maker) understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. Therefore, vaccination against influenza is recommended each year.
- I (resident/decision maker) understand that I resident) cannot get influenza from the influenza vaccine.
- The consequences of my (resident/decision maker) refusing to be vaccinated could have life-threatening consequences to my (resident) health and the health of those with whom I (resident) have contact, including other residents in this healthcare facility, the staff in this facility, my (resident) family and friends and my (resident) community.
- I am authorized to make this health care decision for myself (resident), or this resident (healthcare decision maker) However, it is my decision to decline the vaccination at this time, regardless of the information that I have received about its importance and the risk of not receiving it. I understand the consequences of my decision, including the continuity of risk of endangering my (resident) health and of others from being infected due to influenza. I understand that I may choose to receive the vaccination at any time, understanding receival is based on vaccination availability.

By signing this form, I hereby declare and acknowledge that I have read and fully understand the information on this form.

_____ _____

Print Name of Resident or HCP/Decision Maker/Legal Guardian — Relationship to Resident

_____ _____

Signature of Resident or HCP/Decision Maker/Legal Guardian — Date

Below is for Facility Use Only

☐ Check if verbal consent obtained — _____ Date _____ Time

_____ _____

Print Name of Witness #1 — Print Name of Witness #2