

Influenza Vaccination Declination  
Form 2022-2023

Name \_\_\_\_\_

Ph# \_\_\_\_\_

EID or MRN # \_\_\_\_\_

**I had the 2022-2023 Flu Vaccine** at: \_\_\_\_\_  
(Location and Date)

**I DO NOT WANT THE FLU VACCINE:**

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills as many as 36,000 Americans may 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 takes 2 weeks to develop. In California, influenza usually begins circulating in November and continues through March or April.
- I understand that the Influenza vaccine cannot transmit Influenza and it does not prevent all disease.

I have declined to receive the influenza vaccine for the 2022-2023 season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

- \*Because I have refused vaccination for influenza, I have been advised that in order to protect the safety of my patients and myself during this flu season, I will be required to wear a mask if there is a county public health or Kaiser Permanente mandate. If there is no mandate for my area, then I am strongly encouraged to wear a mask when delivering patient care or working in patient care areas.**

**Knowing these facts, I choose to decline vaccination at this time.** I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand this declination form.

I **decline vaccination** for the following reason(s). Please check all that apply

- My philosophical or religious beliefs prohibit vaccination.
- I have an allergy or medical contraindication to receiving the vaccine.
- I do not wish to say why I decline.
- Other reason – please tell us. \_\_\_\_\_

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring seasonal influenza. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring influenza. If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

Signature \_\_\_\_\_ Date signed \_\_\_\_\_