EMPLOYEE INFLUENZA VACCINATION / DECLINATION RECORD

_____ ***Please check if received flu vaccine elsewhere.*** _____ ***Date of Vaccination, attach documentation.***

EVERYONE MUST COMPLETE THIS SECTION (Please Print):

Employee ID#: _____ **Job Title:** _____ **Dept #** _____

Last Name: _____ **First Name:** _____ **MI:** _____

Birth date: _____ **Last 4 SS #:** _____ **Home/Cell Telephone Number:** _____

I give my consent to receive an influenza vaccination. I have been offered the *Vaccine Information Sheet* (VIS) from CDC.

Yes	No	
❒	❒	Have you ever had a severe allergic reaction to eggs?
❒	❒	Have you ever had neurological problems within 6 weeks of taking a flu shot?
❒	❒	Have you ever had a severe reaction to the influenza vaccine requiring medical attention?
❒	❒	Are you currently ill or have a fever?

CHECK ONE-if applies

- ☐ Clinical Resource Team (CRT)
- ☐ Provider – OSF Employee
- ☐ Provider – NON- OSF Employee
- ☐ Pharmacy (List Facility :_____)
- ☐ Case Management (List Location :_____)
- ☐ Student (List School :_____)
- ☐ Volunteer

CHECK ONE

- ☐ OSF Ministry Services
- ☐ St. Francis Medical Center-Peoria
- ☐ St. Anthony Health Center- Alton
- ☐ St. Anthony Medical Center
- ☐ St. Joseph Medical Center
- ☐ St. Mary's Medical Center
- ☐ St. Elizabeth Medical Center
- ☐ St. James-John Albrecht Medical Ctr
- ☐ St. Francis Hospital-Escanaba
- ☐ Heart of Mary Medical Center
- ☐ OSF St. Francis Inc
- ☐ OSF Home Care
- ☐ OSF Multi-Specialty Group
- ☐ OSF Holy Family Medical Center
- ☐ St. Paul Medical Center
- ☐ St. Luke Medical Center
- ☐ Sacred Heart Medical Center

I do not want this vaccine to be added to my EPIC EMR_____ (initial)

Signature of person to receive the vaccine:

X _____ Date: _____

My employer or affiliated health facility, **OSF Healthcare**, has recommended that I receive an influenza vaccination in order to protect myself and the patients I serve. **I am choosing to decline influenza vaccination** at this time. I understand that I am to wear a mask during high or peak influenza rates as based on recommendations by Infection Prevention and Occupational Health.

Signature of person to decline the vaccine:

X _____ **Date:** _____

MUST note reason for declining influenza vaccine: Medical documentation of condition or allergy is required.

___ I have a medical exemption (must provide documentation to Employee Health for evaluation) see below:

___ Allergic to (**circle one**) eggs, thimerosal, formaldehyde, or latex ___ ***Serious*** reaction to flu vaccine in past

___ I hold a sincere religious belief contrary to vaccination (may be reviewed by OSF panel)

If you declined the vaccine based on one of the above reasons, do you have contact with patients?

___ Yes, specify department and job role: _____

___ No

Office Use Only:

Manufacturer: _____ Lot # _____ Expiration Date: _____

Site: ❒ Left Deltoid ❒ Right Deltoid Administrator's Signature: _____ Date: _____

❒ Agility Database Entry ❒ Agility Scan