

Employee ID#: _____

Name: _____

Date: _____

Please return via FAX at
(713) 745 - 3352 / (713) 745 - 7164
or EMAIL to
HREmployeeHealth@mdanderson.org



INFLUENZA VACCINE WAIVER/DECLINATION FORM

Influenza vaccine is **STRONGLY RECOMMENDED FOR HEALTHCARE WORKERS**, not only to protect themselves, but to reduce the chance of spreading influenza to our patients and community. Influenza infection can lead to serious complications and can be fatal, especially in elderly or sick persons, including those who are hospitalized. When infection occurs despite vaccination, it is usually milder. Employee Health & Well-being is committed to the health and well being of our employees, employee's families and patients, and considers influenza vaccination of all MDACC employees a high **PATIENT SAFETY** priority. The influenza vaccine is provided to all **MDACC EMPLOYEES AT NO COST**.

PLEASE HELP PREVENT THE TRANSMISSION OF INFLUENZA BY RECEIVING ANNUAL INFLUENZA VACCINATION

QUESTION	Yes	No
1. Do you have a history of allergy to chicken eggs, chicken, chicken feathers or chicken dander?		
2. Are you allergic to mercury, or to the preservative thimerosal, which contains mercury?		
3. Do you have previous history of adverse reactions to influenza vaccine?		
4. Do you have any active neurologic disease, or with a past history of Guillain-Barre syndrome?		
5. Are you receiving immunosuppressive drug therapy? <i>If yes, please consult with your physician before receiving the vaccine.</i>		

IF YOU HAVE ANSWERED YES TO QUESTIONS 1 THRU 5, PROCEED TO WAIVER OF VACCINE SECTION.

WAIVER

WAIVER OF VACCINE – Complete if not eligible to receive vaccine

- I am not eligible to receive the influenza vaccine today based on reason(s) marked above.
- Other(s): _____

Signature : _____

Date: _____

DECLINATION

DECLINATION OF VACCINE - Please complete only if refusing the vaccine

I am eligible to receive the influenza vaccine BUT DO NOT WANT to take it. I understand that by refusing the vaccine I may be putting my SELF, FAMILY, and PATIENTS at risk of getting influenza. I am aware that hospitalized patients are at increased risk of getting serious complications following influenza infection.

PLEASE CHECK YOUR REASON(S) BELOW for not receiving the influenza vaccine:

- | | | |
|---|---|---|
| <input type="checkbox"/> I don't get sick | <input type="checkbox"/> I think the flu shot could cause the flu | <input type="checkbox"/> I don't think the flu shot works |
| <input type="checkbox"/> I don't like shots/needles | <input type="checkbox"/> I am concerned about possible side effects | |
| <input type="checkbox"/> Other(s): _____ | | |

Signature : _____

Date: _____