



Kaleida Health

DECLINATION OF INFLUENZA VACCINATION FOR HEALTH CARE PERSONNEL

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention’s (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I 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 and all other healthcare personnel to protect this facility’s patients from influenza, its complications and death.
• If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients and coworkers in this facility.
• If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
• I 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. This is why vaccination against influenza is recommended each year.
• I understand that I cannot get influenza from the influenza vaccine.
• The consequences of my refusing to be vaccinated could have life threatening consequences to my health, and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
• Because I have refused vaccination against influenza, regardless of the reason, I will be required to wear a surgical mask in areas where patients or residents are typically present during the period of time that influenza is designated “prevalent” by the Commissioner of the NYSDOH.

I have read the information above regarding the Seasonal Influenza Vaccine and:
[] I have a medical condition that might be worsened by the vaccine.
[] Although I have been informed of the risks and benefits of the vaccine, I do not wish to receive it.
I am aware that I can change my mind at any time and accept an influenza vaccination.
Employee Name (print) _____ Employee ID# _____
Signature _____ Date _____ Date of Birth _____
Attach Medical Exemption Form DOH-4482 (10/10) for any medical contraindication

Return Completed Declination Form to:
Kaleida Corporate Employee Health Department
726 Exchange Street, Suite 240
Buffalo, NY 14210
OR
Return via Interdepartmental Mail