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**Influenza Vaccination Consent Form**

**Resident Information**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_/\_\_\_/\_\_\_\_

**Screening for influenza vaccine eligibility**

 1. Do you have a severe allergy to eggs? □ Yes □ No

 2. Have you ever had a life-threatening reaction to the influenza vaccine? □ Yes □ No

 3. Do you have a history of Guillain-Barre Syndrome? □ Yes □ No

 4. Are you moderately or severely ill today? □ Yes □ No

*If yes to any questions 1-3 then DO NOT vaccinate with influenza vaccine. If yes to question 4, vaccinate when resident has recovered.*

I have read or had explained to me the Vaccination Information Statement about influenza vaccination and I understand the benefits and risks of influenza vaccination. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**To be completed by person administering vaccine**

Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_ Flu Season Dates: 20\_\_\_\_ - 20\_\_\_\_

Site of Injection: □ R □ L Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Influenza Vaccination Declination Form**

**Resident Information**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_/\_\_\_/\_\_\_\_

**I acknowledge that I am aware of the following facts:**

* Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
* People 65 years of age and older account for approximately 90% of flu-related deaths and more than 60% of flu-related hospitalizations in the United States each year.
* If I contract influenza, I can shed the virus for up to 24 hours before symptoms appear, increasing the risk of transmission to others.
* 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 change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
* I understand that I cannot get the flu from the flu vaccine.
* I understand that the Centers for Disease Control and Prevention recommends influenza vaccination for all people 6 months of age and older and especially for people 65 years of age and older because they are at greater risk for serious complications from influenza.
* I understand 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.

***Knowing these facts, I choose to decline the influenza vaccination at this time.*** I may change my mind and accept vaccination later, if vaccine is available.

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

□ I have already received the 2021 - 2022 flu vaccine (verified).

□ I believe I will get influenza if I get the vaccine. □ I do not like needles.

□ My religious beliefs prohibit vaccination. □ I have an allergy or medical contraindication to receiving the flu vaccine.

□ Other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read or had explained to me this information and fully understand the information on this declination form. I am declining the opportunity to receive the influenza vaccine (or the person named above for whom I am authorized to make this decision).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Resident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_