**VACCINATION DECLINATION/VERIFICATION**

2023-2024

**EMPLOYEE INFORMATION**

|  |  |
| --- | --- |
| **LAST NAME:** | **FIRST NAME:** |
| **RANK:** | **DATE OF BIRTH:** |

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

* Influenza and COVID 19 are serious respiratory diseases. Each year in the United States, each kills thousands of people and causes hundreds of thousands of hospitalizations.
* The Department of Public Health and CDC strongly recommend Influenza/COVID vaccination for me and all other healthcare personnel to protect our staff and our patients from influenza/COVID, its complications, and death.
* If I contract influenza/COVID, I can shed the virus for 24 hours before any symptoms appear.
* During the time I shed the virus, I can transmit influenza/COVID to patients and staff in this building.
* If I become infected with influenza/COVID, even if my symptoms are mild or non-existent, I can spread influenza/COVID to others.
* Symptoms that are mild or non-existent in me can cause serious illness and death in others.
* Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. Influenza usually begins circulating in early December and continues through March.
* I understand that the influenza/COVID vaccine cannot transmit disease to me and it does not prevent other respiratory illnesses.
* I may be required to wear a surgical mask during peak influenza and COVID outbreaks by the Department of Public Health.
* I understand that I need to report any symptoms to a Shift Officer or member of the Command Staff.

**INSTRUCTIONS**: complete Option 1 OR Option 2 citing reason.

* Option 1- Reason(s) for declination of Influenza Vaccination:

 □ Medical Precaution or Contraindication
□ Religious Belief

□ Personal Belief

* Option 2- Reason(s) for declination of COVID Vaccination:

 □ Medical Precaution or Contraindication
□ Religious Belief

 □ Personal Belief

* Option 3-Proof of Vaccination:

 I have received the

 □ COVID-19

 □ Influenza.

Please indicate where and *provide proof of vaccination* with this form:

□ Primary Care Physician
□ Occupational Health
□ Pharmacy

□ Urgent Care
□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I acknowledge and confirm that the above information is correct.**

Signature: Date:

Date Received /staff initials: \_\_\_\_\_\_\_/