University Health Service
HEALTH PROFESSION STUDENT
INFLUENZA VACCINE DECLINATION FORM

Complete form as follows and **return to UHS:** uhsocchealth@uhs.rochester.edu

Section I: If you have a medical contraindication.
Section II: For all persons declining to be vaccinated.

Section I. Contraindication to vaccine

Persons with severe egg allergies should not get the vaccine. If you have a history of Guillain-Barre Syndrome you should consult with your physician to determine the risk/benefit of receiving the vaccine.

☐ I have been advised by my physician not to receive the vaccine due to an allergy or medical contraindication.

Student ID /Title_____

Section II. Refusal/declination of vaccine

Strong Memorial Hospital, based on recommendations from the New York State Health Department (NYSDOH) and the Center for Disease Control (CDC), advises me to get a flu vaccine in order to protect myself, the patients I serve, and my co-workers from the flu and its complications, including death. It is being offered to me at no charge.

I acknowledge the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- If I get influenza (flu), I could spread the virus to patients, staff, or my family, for 24–48 hours before symptoms appear.
- Influenza strains change every year and vaccine received in a prior year does not usually provide immunity to this year's strains of influenza.
- I **cannot** get the flu from the flu vaccine.
- Flu vaccine **is recommended** for women who are pregnant or breastfeeding, and anyone with a weakened immune system. If you have any concerns, consult with your physician to make a decision.
- I understand by not receiving the Flu vaccine, **I continue to be at risk for Influenza infection** which could endanger my health, the health of my patients, and my coworkers.

Despite these facts, I choose not to receive the vaccine for the following reason(s);

_____

Strong Memorial Hospital may reassign me and/or require that I wear a mask during influenza season in the interest of patient safety.

Employee Name _____ Employeet ID#_____

Signature _____ Date _____

Please return this form to University Health Service Box 270617