WAGNER COLLEGE

Evelyn L. Spiro School of Nursing

INFLUENZA VACCINE

*REQUIRED ANNUALY DUE BETWEEN SEP 1 - SEP 31 *

DATE: ☐ BS ☐ 15MONTH ☐MS ☐ DNP

LAST NAME	FIRST NAME	Date of Birth	WAGNER ID
ADDRESS	CITY, STATE	ZIP	
GENDER IDENTITY ☐ Male ☐Female ☐Other	PHONE (cell)	Email	

DO NOT WRITE BELOW THIS LINE **DO NOT WRITE BELOW THIS LINE**

FLU VACCINE CONSENT

TODAYS DATE_____

1	Have you had a flu shot before?	YES	NO
2	Are you sick today?	YES	NO
3	Are you allergic to eggs?	YES	NO
4	Do you have a history of Guillain-Barré syndrome or a persistent neurological illness?	YES	NO
5	Are you allergic to Thimerosal (Preservative found in contact lens solution), any vaccine ingredient, or latex?	YES	NO

I have read and received the Vaccine Information Sheet for the Flu Vaccine and understand the risks and side effects associated with the vaccine.

Patient Signature_____

LOT #_____ Clinician Signature_____ STAMP_____

OR

Influenza vaccine declination

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Flu virus changes often, making annual vaccination is necessary.
- I acknowledge that influenza vaccination is recommended by the CDC for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

Patient Signature_____

Clinician Signature_____ STAMP _____