Seasonal Influenza Vaccination Declination
2023-2024

RotaCare Bay Area, Inc.
Free Medical Clinics

RotaCare Bay Area has recommended that I receive the seasonal influenza vaccination to protect myself, patients, staff, volunteers, and others in the healthcare facility.

I acknowledge that I am aware of the following facts (*please read and initial*):

____ Influenza is a serious respiratory disease that kills thousands of people in the United States each year.

____ Influenza vaccination is recommended for me and all other healthcare workers/volunteers 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 in this facility.

____ If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others, and they can become seriously ill.

____ 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. Therefore, vaccination against influenza is recommended each year.

____ I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.

____ The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of everyone with whom I have contact, including my fellow coworkers/volunteers and all patients in this healthcare facility.

Despite these facts, I choose to decline vaccination against influenza for the following reasons:

____

____

____ I am aware that I can change my mind at any time and accept influenza vaccination if vaccine is still available.

____ I understand that by declining influenza vaccination, I will be required to wear, at a minimum, a surgical mask at all times in all patient care areas (*KN95 is highly recommended*).

____ I am aware that the Clinic Operations Manager and Medical Director will be notified of my decision.

By signing below, I acknowledge that I have read and fully understand the information on this declination form.

Signature____ Date__________________

Name (PRINT)____________________________________

RotaCare_______________________________________Free Medical Clinic

Clinic Function/Position___________________________

Received by:

☐ Clinic Operations Manager: ___________________________ Date__________________

☐ Medical Director: ___________________________________ Date__________________