## HEALTH CARE PERSONNEL INFLUENZA VACCINATION FORM

I am a VA: ___Employee ___ Volunteer ___ Trainee (residents, interns and students)

☐ I received the seasonal influenza vaccine this flu season (required documentation is attached.)

☐ I decline to receive seasonal influenza vaccine at this time for the following reason:

Select the single answer that best fits your reason:

- ☐ I do not like needles. Heroin Addict
- ☐ I have a philosophical or religious reason for not receiving the vaccine. Paranoid Schizophrenia
- ☐ I have an allergy to the vaccine or one of its components. Hypochondriac
- ☐ I am concerned about the side effects/safety of the vaccine. Anxiety Disorder
- ☐ I have never had the flu and don't think I will this season. Narcissistic Personality Disorder
- ☐ I have another reason. (Please explain) Borderline Personality Disorder

_____

They never help anyways, why should I take it? _____

I acknowledge that VHA policy requires health care personnel to receive the influenza vaccine every year. I understand that if I decline to receive the vaccine and/or to provide proof of vaccination by November 30 or within two weeks of beginning employment if after November 30, I must wear a face mask according to requirements and guidelines within the Directive 1192, Seasonal Influenza Prevention Program. I understand that violation of the directive may result in disciplinary action.

I have read and fully understand the information on this form and have been given the opportunity to have my questions answered.

Signature: _____ Date: _____

Name (print): _____ Last 4 SS# _____

Dept./Serv: _____ Supervisor: _____

***Employees and volunteers provide this form to the facility Employee Occupational Health Office. Trainees provide this form to the Designated Education Officer.***

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**FOR OFFICE USE ONLY**

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## Vaccination Information

Employee provided the Influenza Vaccine Information Statement. ☐ yes ☐ no

Employee medically cleared (no contradictions) to receive vaccination. ☐ yes ☐ no

Comments (if needed): _____

Date given: _____ Mfg./Lot#: _____

Deltoid site: ☐ left ☐ right

_____ _____ _____

Printed name of Administering HCP Extension Signature