TRUECARE

FLU VACCINE DECLINATION

Print Name ______________________ Date of Birth ____ / ____ / ____
Month Day Year

I DO NOT WANT A FLU SHOT

I acknowledge that I am aware of the following facts:

- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the 2025-2026 season. I acknowledge that the influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.
- As per the Department of Health, if you choose **NOT** to be vaccinated you **MUST WEAR A MASK** whenever you are in the presence of a patient; mask's will be provided by the agency **ONLY** if you decline the vaccination.
- **My supervisor and manager, including division and departmental leadership will be notified that I declined.**

I DECLINE VACCINATION for the following reason(s).

Please check all that apply. Reasons i do not wish to take the vaccine –

Please check all that apply.

⑤ I don't believe this vaccine is important.

⑤ I am concerned about side effects.

⑤ I never get the flu.

⑤ I have had a reaction to flu shots.

⑤ I don't like needles.

Knowing these facts, i choose to decline vaccination at this time.

I have read and fully understand the information on this declination form.

____
Print Name

____
Signature

Date ____ / ____ / ____
Month Day Year