FULL RANGE HEALTH SERVICES®
Your Life. Your Goals. Your Way.

Tel: 610.241.2685
Fax: 877.732.7311
WWW.FULLRANGEHEALTH.ORG

FLU VACCINATION - EMPLOYMENT RECORD

NAME:_____ DATE: _____

FLU VACCINATION STATEMENT

I HAVE READ, OR HAVE HAD EXPLAINED TO ME, THE CDC VACCINE INFORMATION STATEMENT ABOUT INFLUENZA AND THE INFLUENZA VACCINE. I UNDERSTAND THAT THIS VACCINE MAY CAUSE FLU-LIKE SYMPTOMS IN SOME PEOPLE AND IN RARE INCIDENTS GUILLAIN-BARRÉ SYNDROME. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF INFLUENZA VACCINE AND REQUEST THAT THE VACCINE BE GIVEN TO ME (OR PERSON NAMED BELOW FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST).

SIGNATURE BELOW REQUIRED:

NAME (PRINTED): _____ DATE: _____

SIGNATURE _____

SCREENING QUESTIONNAIRE (OPTIONAL – ONLY NEEDED IF REQUIRED BY PHYSICIAN)

ARE YOU CURRENTLY ILL OR DO YOU HAVE A FEVER?	___YES	___ NO	___ UNKNOWN
HAVE YOU RECEIVED THE VACCINE BEFORE?	___YES	___ NO	___ UNKNOWN
HAVE YOU HAD A REACTION TO THE VACCINE BEFORE?	___YES	___ NO	___ UNKNOWN
HAVE YOU BEEN SICK IN THE LAST 2 WEEKS?	___YES	___ NO	___ UNKNOWN
ARE YOU ALLERGIC TO EGG OR DAIRY PRODUCTS?	___YES	___ NO	___ UNKNOWN
ARE YOU ALLERGIC TO THIMEROSAL?	___YES	___ NO	___ UNKNOWN
ARE YOU PREGNANT?	___YES	___ NO	___ UNKNOWN
ARE YOU A HEALTH CARE WORKER?	___YES	___ NO	___ UNKNOWN
HAVE YOU EVER HAD GUILLAIN-BARRE SYNDROME?	___YES	___ NO	___ UNKNOWN
DO YOU HAVE A BLOOD-CLOTTING DISORDER?	___YES	___ NO	___ UNKNOWN
ARE YOU TAKING BLOOD-THINNING MEDICATION?	___YES	___ NO	___ UNKNOWN

OPTIONAL SECTION – PLEASE DISREGARD THIS SECTION IF YOU HAVE SUBMITTED THE IMMUNIZATION RECORD OF YOUR SEASONAL INFLUENZA SHOT.

DATE GIVEN: _____ LOT NUMBER: _____ EXP DATE: _____

SITE: RT____ LT____ RD____ LD____

ROUTE: _____ ADMINISTERED BY: _____

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FLU VACCINATION DECLINATION OPTIONS

DECLINATION/EXEMPTION OPTIONS AND REQUIREMENTS

I AM REQUESTING AN EXEMPTION TO RECEIVING THE ANNUAL INFLUENZA VACCINE DUE TO ONE OF THE FOLLOWING REASONS. I UNDERSTAND THAT EACH REQUEST FOR EXEMPTION/DECLINATION WILL BE REVIEWED BY THE HUMAN RESOURCES DEPARTMENT. IF MY REQUEST IS INCONSISTENT WITH MY PRIOR VACCINATION HISTORY, I HAVE EXPLAINED THE REASON FOR THAT INCONSISTENCY.

DECLINATION/ EXEMPTION OPTION 1:

_____ (INITIAL) DOCUMENTED ALLERGY TO EGG

_____ (INITIAL) DOCUMENTATION OF ALLERGY TESTING BY ALLERGIST IS ATTACHED.

DECLINATION/ EXEMPTION OPTION 2:

_____ (INITIAL) DOCUMENTED HISTORY OF GUILLAIN-BARRE SYNDROME

_____ (INITIAL) MEDICAL DOCUMENTATION MUST BE ATTACHED.

DECLINATION/ EXEMPTION OPTION 3:

_____ (INITIAL) MY RELIGIOUS BELIEFS

_____ (INITIAL) A BRIEF EXPLANATION FOR MY REQUESTED RELIGION EXEMPTION FROM MY PARISH PRACTITIONER.

_____ (INITIAL) IF MY REQUEST IS INCONSISTENT WITH MY PRIOR VACCINATION HISTORY, I HAVE EXPLAINED THE REASON FOR THAT INCONSISTENCY.

_____ (INITIAL) I HAVE ATTACHED DOCUMENTATION FROM MY RELIGIOUS ORGANIZATION THAT EXPLAINS/ VERIFIES THE SINCERITY AND RELIGIOUS NATURE OF MY PERTINENT RELIGIOUS BELIEFS SUCH AS A LETTER FROM MY CLERGY ON CHURCH LETTERHEAD.

I UNDERSTAND THAT FAILURE TO BE IMMUNIZED OR GRANTED AN EXEMPTION BY THE DATE DETERMINED BY THE ORGANIZATION WILL RESULT IN SUSPENSION. SUSPENDED EMPLOYEES WILL BE GIVEN TWO WEEKS TO COMPLY OR WILL FACE TERMINATION.

NAME (PRINTED): _____ **DATE**: _____

SIGNATURE: _____