Occupational Health and Safety

Influenza Vaccine Consent/Decline Form
2013– 2014

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease and up to 30% of people with influenza have no symptoms, allowing transmission to others and,
- Influenza virus may be shed for up to 24 hours before symptoms begin, allowing transmission to others and,
- Influenza virus strains change often, making annual vaccination necessary and,
- I understand that flu vaccine cannot transmit influenza.

I have read the above influenza vaccine information and had an opportunity to ask questions and/or get further information through Occupational Health and Safety (OHS). I understand the benefits and risks of the influenza vaccine. In the event of an outbreak at Royal Victoria Regional Health Centre, my vaccination status will be released to my manager, Infection Prevention and Control and the Simcoe Muskoka District Health Unit.

If I decline to receive the influenza vaccine at this time, I may change my mind and accept vaccination later, if vaccine is available. According to the **Public Health Act** (1994) and collective agreements which state that health care workers who choose not to be immunized pose risk to patients and co-workers and in the event of an outbreak in a health care facility the exclusion of any person who presents a risk to the health of patients will occur.

______________________	____________	____________________
PRINT NAME	**EMPLOYEE ID #**	**DEPARTMENT/LOCATION**

PLEASE CHECK **<u>ONLY</u>** ONE OPTION BELOW:

☐ **YES – I choose to be immunized**
I consent to being immunized by OHS officials with the influenza vaccine for the 2013 – 2014 season and agree to report any unexpected adverse event following immunization to OHS.

OR

☐ **NO – I have been immunized elsewhere** (please attach proof, you may use confirmation form below for proof of immunization elsewhere)

OR

☐ **NO – I choose not to be immunized for personal reasons**.
I am choosing not to be immunized against influenza at this time. I am aware of the facts detailed above and understand my organization is committed to immunizing all personnel as part of its commitment to infection prevention and workplace health. I understand that in the event of an influenza outbreak, there may be repercussions (such as work reassignment, wearing personal protective equipment or other safety measures) as outlined in my organization's influenza immunization policy 1.098.

OR

☐ **NO – I have a written medical exemption from a health professional** (Please provide proof)**.**

________________________________	______________________
SIGNATURE	**DATE**

FOR OCCUPATIONAL HEALTH AND SAFETY DEPARTMENT USE ONLY

Vaccine Name: ________________ **Injection Site: Deltoid**
Lot #: ________________
Exp. Date: ________________ Left Right

Medical Directive: Administration of Influenza Vaccine OH-1, 03/12

Administered by: (please print) ____________________ **Signature:** ________________ **Date:** ____________

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Occupational Health and Safety
Proof of Immunization

Please be advised that:

______________________________ ______________
Name (Please Print) Employee Number

has been administered the influenza vaccine:

Vaccine Name: ____________
Lot #: ____________
Exp. Date: ____________

by a healthcare provider on:

(date) ____________________

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Healthcare Provider Signature

Revised Sept 2013