EMPLOYEE HEALTH SERVICES



DECLINATION 2024-25 SEASONAL INFLUENZA

Mandatory Employee Health 2024-25 SEASONAL INFLUENZA Vaccine Declination

Centers for Medicare and Medicaid Services require acute care hospitals to report data to the Centers for Disease Control and Prevention (CDC) and the State on influenza rates for workforce members. All information will be handled in a confidential manner. Please complete the form and return it to Employee Health Services for processing. To protect your information, you may complete this form and place it in a sealed envelope.

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							DOB (MM/DD/YY)						E or C #							
PLEASE PRINT LEGIBLY								/		1										
LAST NAME									FIRST	ΓΝΑΝ	1E									
																			1 1	
☐ LA GENERAL MEDICAL CENTER ☐ RANCHO, on Rehab Unit ☐ Yes ☐ No ☐ HSA ☐ EMS ☐ LA GENERAL HAWKINS ☐ CORRECTIONAL HEALTH ☐ COMMERCE														EMS :F						
HARBOR	, on 8\	N/Psy	ch, ED		RU 🗆 Yes 🗆 No 🔲 JUVENILE COURT 🔲 MLK											_				
OLIVE VIEW, on 6A/6C Yes No ACN (SPECIFY): OTHER_													ER							
E # STAFF				C # STAFF																
Paid by DHS Yes Title: OR Dept.:				Contract, Non-County/Non-DHS Workforce Member																
				Paid by other or non-comp (check one-circle):																
			0.0																	
			UR		Physician Assistant Advanced Practice Nurse															
Ext.:		Adult Student/ Trainee																		
		Contractor Jr Volunteer (age <18) County, non-DHS: DPH, DMH, ISD, Sheriff, Coroner,																		
SECTION I: MEDICAL CONTRAINDICATIONS																				
				HE APPROPRIATE BOX																
			ad a severe allergy reaction (e.g., anaphylaxis) after previous vaccine?																	
☐ ☐ Do you have a history of Guillain-Barré syndrome within 6 weeks after a previous influenza vaccine?											ne?									
SECTION I	1-11	OO NO	T W	ANT A	4 FL	J SH	IOT (Must c	omple	te in f	ull if	dec	linir	ng)						
								nfluenza s												
CDC for all healthcare personnel to prevent infection from transmission of influenza and its complications, (including death), to my patients, my co-workers, my family, and my community. I understand the benefits and risks of the influenza vaccine. I understand that if I decline the vaccine,																				
I may change my mind and receive an influenza vaccine, if still available, by reporting to Employee Health.																				
I decline vaccination for the following reason(s):																				
☐ I believe I can get the flu if I get the shot. ☐ I do not like needles. ☐ I have a medical contraindication. ☐ It is against my philosophical or personal belief system.																				
Is there anything that would change your mind to get vaccinated?																				
Do you provide direct patient care? Yes □ No □																				
													aroac							
I am aware that I will be required to wear a surgical mask starting Nov. 1st - April 30th, during work hours in patient care areas. Must include completed post-test Solution																				
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Your Sig	nature								_		Date									
Tour Sig	idiale				ΕM	IDI C	VEE	HEAL	LH CE			NI V	7							
					_ LIV															
Date receive	:d:					Po	st-Test	attached	E	ntered	into d	datak	base		In	itials				

REV 8/2024