



INFLUENZA VACCINE DECLINATION STATEMENT

Please print information below:
Employee Name: _____ Date of Birth: ___/___/___ Title/Position: _____
Department: _____ Supervisor: _____ Personal Phone #: _____

PLEASE CIRCLE ONE: EMPLOYEE JHLAB MD/PA/ALLIED HEALTH VOLUNTEER AGENCY
CONTRACTUAL-BROADWAY CONTRACTUAL-DIETARY OTHER: _____

Declination of Annual Influenza Vaccination:

- I understand that due to my occupational exposure, I may be at risk of acquiring infection. In addition, I may spread influenza to my patients, other healthcare workers, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications.
- I have received education about the effectiveness of the influenza vaccination as well as the adverse events. I have also been given the opportunity to be vaccinated with influenza vaccine, at no charge to myself. However, I decline influenza vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring influenza, potentially resulting in transmission to my patients. If in the future I want to be vaccinated with influenza vaccine, I can receive the vaccine at no charge to me.
- I attest that I will wear a mask anytime I am within six feet of a patient for the duration of the influenza season if I do not receive the influenza vaccination.

Reason for declining: (Please check all that apply.)

- ___ I received the vaccine from another facility (Documentation must be provided to Occupational Health or Medical Staffing Office for Professional Staff.)
- ___ I request a medical exception (The Medical Exception Form must be completed and returned to Occupational Health.)
- ___ I request a religious accommodation (The Religious Accommodation Form must be completed and returned to Human Resources.)

Please send this form to Howard County General Hospital:

Employees and Volunteers: Howard County General Hospital Occupational Health 5755 Cedar Lane Columbia, MD 21044 Office: 410-740-7838 Fax: 410-740-7685 Occupationalhealth@hcgh.org	Professional Staff and Allied Health: Howard County General Hospital Medical Staffing Services 5755 Cedar Lane Columbia, MD 21044 Office: 410-740-7544 Fax: 410-740-7561
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Employee **Signature:** _____ **Date:** _____

DESIGNATED OFFICE USE ONLY
Declination Statement Received On: ___/___/___ Approving Staff Signature: _____

*APPENDIX 2: CRITERIA FOR MEDICAL EXCEPTION

Medical exceptions include:

1. Severe allergy to eggs or vaccine components;
2. Guillian-Barré within six (6) weeks of receiving an influenza vaccine.

OHS will evaluate the allergy history and determine a course of action based on severity.

- Individuals who report non-severe reactions to egg (e.g., hives) may have influenza vaccine if additional measures are taken.
- Those patients who are able to eat eggs, cake or foods with egg protein without reaction may receive the vaccine.
- Individuals who have experienced less severe reactions to egg (hives only) may receive influenza vaccine with the following additional measures:
 1. Killed influenza vaccine formulation (TIV) should be used; preferably vaccines with less than 0.12 mcg of egg protein should be administered.
 2. Patients should be observed for 20-30 minutes for signs of a reaction following administration of each vaccine dose.

If OHS determines that there is a history of a severe allergic reaction to the vaccine or its components, an allergy consultation can be offered. (Other measures, such as dividing and administering the vaccine by a two-step approach and skin testing with vaccine are not necessary.) This should include persons who report having had serious reactions to egg involving such symptoms as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or, who required epinephrine or other emergency medical intervention, particularly those that occurred immediately or within a short time following egg exposure (minutes to hours), are most likely to have a serious systemic or anaphylactic reaction upon re-exposure to egg proteins. Prior to receipt of vaccine, such individuals will be referred to an allergy specialist for further risk assessment. Preferably vaccines with less than 0.12 mcg of egg protein should be administered.

If the patient reports a history of Guillian-Barré from any cause in the past six (6) weeks, the individual may be referred to a neurologist with expertise in this area.



HOWARD COUNTY
GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

REQUEST FOR MEDICAL EXCEPTION FROM INFLUENZA VACCINATION

Please print information below:

Employee Name: _____ Date of Birth: ____/____/_____
 Employee E-mail: _____ Personal Phone #: _____
 Department: _____ Manager: _____
 Physician Name: _____ Physician Phone #: _____

Dear Physician:

Howard County General Hospital requires influenza vaccination similar to other required vaccinations such as MMR and varicella. For decades influenza vaccinations have been recommended for healthcare workers because they have been shown to be effective in reducing the incidence of influenza in inpatient populations. Influenza vaccination has also been recommended for pregnancy by the Centers for Disease Control to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born. The above named employee is requesting an exception from this vaccination requirement. A medical exception from influenza vaccination is allowed for certain recognized contraindications (CDCMMWR Early Release 2011; Vol. 60. Available online: <http://www.cdc.gov/mmwr/pdf/wk/mm60e0818.pdf> .

Please complete the form below. Should you have any questions, please contact Occupational Health Services at 410-740-7838. Thank you.

The above employee should not be immunized for influenza for the following reason:

- History of previous severe allergic reaction and documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine (including egg allergies).
- History of Guillain-Barre Syndrome within six weeks of receiving a previous vaccine. Please provide a detailed narrative that describes the event.
- Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on a case-by-case basis).

I certify that _____ has the above contraindication and request a medical exception from the influenza vaccination.

Physician Signature: _____ Date: _____
 (Note: THIS IS A MEDICAL-LEGAL DOCUMENT; NO STAMP SIGNATURE)

Physician Medical License No.: _____

PLEASE FAX OR MAIL THIS TO OCCUPATIONAL HEALTH

Howard County General Hospital
 Occupational Health
 5755 Cedar Lane
 Columbia, MD 21044
 (P) 410-740-7838
 (F) 410-740-7865

DESIGNATED OFFICE USE ONLY:

Medical Exception Approved on: ____/____/_____
 Approving Staff Signature: _____