HCA Healthcare
DOWNTIME FORM
2023-2024 Seasonal Influenza Vaccine Declination

Print full name*: _____

E-mail address*: _____ **3/4 ID*:** _____ **Date of birth*:** _____

Vaccine is for a(n)*:

- ☐ Employee
- ☐ Volunteer
- ☐ Student / Trainee
- ☐ Licensed Independent Practitioner (Physician)
- ☐ Licensed Independent Contractor (Other)
- ☐ Dependent Healthcare Professional

I AM DECLINING THE FLU SHOT.

This facility recommended I receive the influenza vaccination in order to protect myself and the patients I serve. *I decline the vaccination at this time, while acknowledging my awareness of the following facts*:

- Influenza is a serious respiratory disease. On average, over 50,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- 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.
    - In California, influenza usually begins circulating in early January and continues through March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I decline to receive the influenza vaccine for the 2023-2024 season. I acknowledge that 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.

REQUIRED CHECK ALLTHATAPPLY: I am declining due to the following reason(s):

- ☐ I have a medical condition
- ☐ My philosophical or religious beliefs prohibit vaccination
- ☐ Other reason (describe): _____

Signature page on back

Declaration of declination

I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.

I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.
I have read and fully understand the information on this declination form.

_____ _____

Signature Date

This form must be entered into the Vaccine Tracking System once completed.