THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center

Employee Health and Well-being 1MC 2.2190 – Unit 1610
(713) 745-6900 Fax (713) 745-3352

INFLUENZA VACCINE
NEW EMPLOYEES & CONTINGENT WORKERS CONSENT/REFUSAL FORM

CONSENT FOR INACTIVATED INFLUENZA VACCINE

I have reviewed the Vaccine Information Statement (VIS) for the influenza vaccination. I have reviewed the Consent Document for Influenza Vaccination and have no medical contraindications to receiving the vaccine.

☐ ***I wish to receive the Inactivated Influenza Vaccine.***

REFUSAL FOR INACTIVATED INFLUENZA VACCINE

QUESTION	Yes	No
1. Have you had a severe (life threatening) allergic reaction to any component of the vaccine including egg protein or to a previous dose of any influenza vaccination?		
2. Do you have a history of allergy to eggs? *If yes, please consult with your physician before receiving the vaccine.*		
3. Do you have a history of Guillain-Barre syndrome (a severe paralytic illness, also called GBS) that has occurred within 6 weeks of receipt of a prior influenza vaccine? *If yes, please consult with your physician before receiving the vaccine.*		

I do not wish to receive Inactivated Influenza Vaccine at this time.

Check appropriate box**:**

☐ I am not eligible to receive the flu vaccine based on reasons marked above.

☐ I am declining receipt of flu vaccine based on reasons of conscience, including religious beliefs.

I understand that by refusing the vaccine I may be putting my SELF, FAMILY, and PATIENTS at risk of getting influenza. I am aware that hospitalized patients are at increased risk of getting serious complications following influenza infection. **I UNDERSTAND THAT I WILL BE REQUIRED TO WEAR A SURGICAL MASK WITHIN SIX FEET OF A PATIENT WHEN ENGAGED IN PATIENT CARE OR HAVING CONTACT WITH PATIENTS WHILE PERFORMING ASSIGNED DUTIES FOR THE DURATION OF THE RESPIRATORY VIRUS SEASON,** which is generally October through March.

_____ _____ _____

PRINT NAME (Last Name, First Name) Signature Date

Employee ID #:_____ Date of Birth: _____

Date VIS Issued:_____RN_____