TROCAIRE COLLEGE

# Declaration of Influenza Vaccination for Healthcare Personnel

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I understand that by refusing the vaccination against influenza, I will be required to wear a surgical mask in areas where patients and residents may be present from November to May of the designated year, or as otherwise designated "prevalent" by the Commissioner of the New York State Department of Health (NYSDOH).

I have read the above information and please check one of the following:

_____ I have a serve allergy to eggs (or other component of the vaccine)

_____ I have a medical condition that might worsen by the vaccine

_____ I do not wish to receive the vaccine because of religious reasons

_____ ***I*** have been informed of the risks and benefits of the vaccine and ***I*** do not wish to receive it

**I am aware that I can change my mind at any time and accept an influenza vaccination.**

**Name (print)** _____

**Signature**_____ **Date**_____

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