Earl R. Wilson, Founding Chairman
METHODIST
REHABILITATION CENTER

Observer Information & Agreement

General Information: (Please Print)

Name _____

Permanent Mailing Address

_____

_____

Email _____Local telephone number _____/_____

Emergency contact _____ _____

Observation Hours Requested

□ PT □ OT □ SLP □ Other _____

Confidentiality Agreement:

I understand that I am committed to an oral and written bond regarding the confidentiality of each patient's medical and personal information with which I may come in contact during the course of my work. I will not release any patient information to my family, friends or anyone else.

Signature _____Date _____/_____/_____

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Declination of Influenza Vaccination

My employer or affiliated health facility, _____, recommends that I receive influenza vaccination to protect myself, patients, staff, and others in the healthcare facility.

I acknowledge that I am aware of the following facts (please read and check each box):

- ☐ Influenza is a serious respiratory disease. Each year in the United States, influenza kills thousands of people and causes hundreds of thousands of hospitalizations.
- ☐ Influenza vaccination is recommended for me and all other healthcare personnel to protect our staff and our facility's patients from influenza, its complications, and death.
- ☐ If I contract influenza, I can shed the virus for 24 hours before any influenza symptoms appear. During the time I shed the virus, I can transmit influenza to patients and staff in this facility.
- ☐ If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread influenza to others. Symptoms that are mild or non-existent in me can cause serious illness and death in others.
- ☐ I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended every year.
- ☐ I understand that it is impossible to get influenza from influenza vaccine.
- ☐ The consequences of my refusal to be vaccinated could have life-threatening consequences for my health and the health of everyone with whom I have contact, including my coworkers and all patients in this healthcare facility.

Despite these facts, I am choosing to decline influenza vaccination for the following reasons:

☐ I understand that I can change my mind at any time and accept influenza vaccination.

I have read and fully understand the information on this declination form.

Signature _____ Date _____

Name (PRINT) _____

Department _____

REFERENCE: CDC. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices - United States, ... Access links to current ACIP recommendations at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html