

**MONROE COUNTY MEDICAL SOCIETY COMMUNITY  
2018 INFLUENZA VACCINATION STATUS FORM  
FOR PHYSICIANS AND ADVANCED PRACTICE PROVIDERS**

Providers are REQUIRED to participate in annual flu vaccination compliance program by either receiving or declining the influenza vaccine. Please select the option below (YES or NO) that best describes your vaccination status, and then return this form (which may be shared with all your associated facilities by checking the options for sharing below) to Medical Staff Services by December 15, 2018. Fax numbers are listed at the bottom of the form.

First Name (print):

Last Name (print):

Date of birth:     
 Month Day Year

**YES, I was vaccinated on or after Aug. 1, 2018.**

**I have attested to consent – included with this form (to assure NYS compliance you must complete)**

I received my flu vaccine from: (write name of clinic) \_\_\_\_\_

Date of vaccination: \_\_\_\_\_ *Required in case of flu outbreak.*  
 Month Day Year

|   |
|---|
| Manufacturer: _____ Lot Number: _____ Exp Date: ____/____/____<br>0.5 mL Deltoid IM ( ) Right ( ) Left Administered by: _____ Date: Given: ____/____/____ |
|---|

- I have read the "Influenza Vaccine Information Statement", which can be found at <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf>
- I have had the opportunity to ask questions which were answered to my satisfaction.
- I understand that some people may experience pain at the site of the injection.
- I am pregnant or breast feeding and understand preservative free vaccine may be used if available.
- I consent to sharing this form with any requesting health care facility.
- I consent to sharing this form only with the following health care facilities outside of this healthcare system: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's date:     
 Month Day Year

**NO, I will not be vaccinated.**

**I understand that, per New York State's Department of Health, I am required to wear a mask during active flu season.**

Reason for declining vaccination:

- I have a medical contraindication to influenza vaccination, defined as:
  - Severe allergic reaction to eggs or other vaccine component(s)
  - History of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination



**Please fax your physician's statement documenting the contraindication to the influenza vaccination to Medical Staff Services at your affiliated hospital(s). Fax numbers listed below.**

- Vaccination conflicts with my religious beliefs/I have other personal objections.
- I do not believe vaccination is important. I never get the flu.
- I am afraid of needles.

Signature: \_\_\_\_\_ Today's date:     
 Month Day Year

**Return by December 15, 2018 via fax to your affiliated hospital(s)**

**UR Medicine Facilities: 585-784-8367 Rochester Regional Health Hospitals: 585-922-0761  
 Rochester Regional Health Surgery Centers: 585-267-8265**