TriHealth

2024-2025 FLU SHOT CAMPAIGN

MEDICAL DECLINATION FOR FLU VACCINATION

INSTRUCTIONS: With this form, you are requesting a Medical Waiver for this year's seasonal influenza vaccination. Answer the following question, complete this form as directed, and **EMAIL the completed form to FluDocumentation@TriHealth.com.**
This form must be received by November 1, 2024 in order to be considered for a medical waiver for this year.

Did you have a MEDICAL DECLINATION approved by TriHealth Employee Health for the same medical reason last year (2023)?

- ☐ **YES. Complete all of Section A and return this form as instructed above. (Section B does not need to be completed.)**
- ☐ **NO. Complete Section A and have your personal physician complete Section B** ("Physician's Medical Documentation for Influenza Vaccination Declination").

SECTION A:

NAME:		**Team Member ID #:**
DOB:	**Phone #:**	**Dept:**

❑ **DECLINE: I do not want the flu vaccination given to me because of a MEDICAL reason.**

I realize that my refusal may put patients, visitors, and family at risk. By declining the influenza vaccine, I understand I am at risk of acquiring influenza. To reduce the risk of exposure to patients and TriHealth team members, I understand I must wear a surgical mask and practice hand hygiene while I am working in patient care areas. If I should develop signs/symptoms of influenza (fever greater than 100.3° with cough, chills, body aches, sore throat, runny nose), I must report the illness immediately to my supervisor and to TriHealth Employee Health.

Signature:_____ **Date:**_____

SECTION B:

PHYSICIAN'S MEDICAL DOCUMENTATION FOR INFLUENZA VACCINATION DECLINATION

TriHealth requires its team members to be vaccinated for seasonal influenza. Team members who have documented medical contraindications to receiving the seasonal flu vaccine may be exempted but are required to wear a mask throughout the entire influenza season as described above.

Your patient has indicated that they have a medical contraindication to receiving the seasonal influenza vaccination and has requested a waiver to TriHealth's vaccination requirement. Please complete the physician section below.

FOR PERSONAL PHYSICIAN TO COMPLETE:

Please indicate below if your patient has a verifiable medical contraindication to receiving the seasonal influenza vaccine with objective documentation in the patient's chart. Please note that a family history alone of an adverse reaction/allergy to the flu vaccine is not considered sufficient to receive a waiver. Egg-free vaccine is available for those previously not able to be vaccinated due to an egg allergy, as well as vaccine that contains no Thimerosal or latex.

- ❑ Documented personal history of **allergy to egg.** (Vaccines are available that do not contain egg.)
  Specify: _____
- ❑ Documented personal history of **allergy to a component of the influenza vaccine**. (Note that vaccine components vary for different manufacturers and formulations. Vaccines are available that do not contain Thimerosal and that do not have latex. A reference matrix of vaccines and components is available by calling TriHealth Employee Health.)
  Specify: _____
- ❑ Documented personal history of significant **adverse reaction to previous influenza vaccine however no specific vaccine component has been identified as the cause of the adverse reaction.**
  Specify: _____
- ❑ Documented personal history of a **neurological disorder that is a current medical contraindication** to receiving the influenza vaccine.
  Specify: _____

Provider Name (printed):_____ Office Phone:_____

Provider Signature:_____ Date:_____

Contact TriHealth Employee Health with any questions or concerns.
Bethesda North - Phone: 513-865-1152 **Good Samaritan** - Phone: 513-862-2857