UNIVERSITY OF HAWAI‘I • KAPI‘OLANI COMMUNITY COLLEGE

Nursing Department

Influenza Vaccination Attestation/Declination Form

Healthcare facilities are recommending that all healthcare workers and students be vaccinated annually with the flu vaccine to protect themselves and the patients they serve from influenza. Healthcare facilities also have the right to refuse students and faculty who do not meet their health requirements relative to the influenza vaccination.

In completing this form, I understand and acknowledge the following information:

• The influenza vaccination arrives every Fall and is available through Spring.
• For the Fall semester, I will need to receive the vaccination that arrives in the Fall season. For example: Entering Fall 2020 semester, I will need the Fall 2020 vaccination. (Any vaccination received prior to Fall 2020 is invalid for the current season.)
• For the Spring semester, I will need to receive the vaccination that arrived the previous Fall if I did not do so already. For Example: Entering Spring 2020 semester, I will need the Fall 2019 vaccination. Any Vaccination received prior to Fall 2019 (August) is invalid.
• I may need to pay out of pocket if I am unable to use my health insurance for any reason to meet my given deadline
• I will need to wear a mask at all times if I have an approved medical contraindication for the influenza vaccination.
• The influenza vaccination is recommended/required for all healthcare facilities to prevent disease and its complications, including death.

Instructions: Please complete one of the sections below indicating that you have or have not received the flu vaccination.

Vaccine Attestation: Please complete this section to confirming you have received the current influenza vaccination, and submit proof of administration of the influenza vaccination. Must include your name, the date you received the vaccination and what was administered (i.e., current influenza vaccination).

I received the current season’s influenza vaccination on __________________________ (MM/DD/YYYY)
from ______________________________ (Name of Provider).

Vaccine Declination: Please complete this section to confirm your decision to decline the flu vaccination and provide a reason for declining the vaccination.

I am choosing to decline the influenza vaccine because of the following medical contraindication(s): (Check the appropriate box.)

□ I have severe anaphylactic reaction to the influenza vaccination.
   Reaction: _______________________________________________________________________
   (Please provide primary care provider’s note.)

□ I had Guillain-Barre syndrome within six weeks following a previous dose of influenza vaccine.
   (Please provide primary care provider’s note.)

□ Other medical contraindication: _______________________________________________________________________
   (Please provide primary care provider’s note.)

Signature of Student ___________________________________________ Date __________________________