



## DISEASE/INFECTION INFORMATION SHEET FOR DECLINED VACCINE

A vaccine for the following disease/infection (as checked) was recommended. This sheet was given to me in order to provide information about the disease/infection, allowing me to make an informed decision about whether to take the vaccine. I am aware that by declining the vaccine, I may be at risk for contracting this disease/infection. Nonetheless, at this time I have opted to decline it. I also understand that I can receive the vaccine at a later date should I chose to do so.

**MEASLES, MUMPS, RUBELLA (MMR vaccine offered)**

**Measles virus** causes rash, cough, runny nose, eye irritation and fever. It can also lead to ear infection, pneumonia, seizures (jerking and staring), brain damage and death.

**Mumps virus** causes fever, headache, and swollen glands. It could lead to deafness, meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, and rarely death.

**Rubella (German measles)** virus causes rash, mild fever, and arthritis (mostly in women). If a woman gets rubella while pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

I understand that the MMR (Measles, Mumps, Rubella) vaccine can protect me against three serious diseases, Measles, Mumps, and Rubella which are all caused by viruses that are spread from person to person through the air.

I further understand that if I contract these diseases, I may spread it to my patients, other healthcare workers, and my family because it is highly contagious through air transmission 4-9 days *before* symptoms appear and up to 4-9 days after the onset.

As a result, I understand I may be restricted from working with patients with Measles, Mumps or Rubella. My supervisor, as well as the Infection Control Chairperson will be notified about these restrictions.

I will be responsible for reporting to my supervisor or Occupational Health, any symptoms that may appear, such as a rash.

**VARICELLA (Varivax Vaccine Offered)**

**Varicella (chickenpox)** is a common childhood disease. It causes a rash, itching, fever, and tiredness. It can lead to severe skin infections, scars, pneumonia, brain damage, or death.

I understand that the Varicella vaccine can protect me against chickenpox which is caused by a virus that can be spread from person to person through the air or by contact with fluid from chickenpox blisters.

I further understand that if I contract chickenpox, I may spread it to my patients, other healthcare workers, and my family because it is highly contagious through air transmission 2 days before symptoms appear, I will also be required to immediately report this to Occupational Health.

**TETANUS, DIPHTHERIA (Td offered)**

**Tetanus (Lockjaw)** is a serious disease that is caused by a germ that enters the body through a cut or wound. It causes serious, painful spasms of all muscles and can lead to "locking" of the jaw which prevents one from opening his/her mouth or swallow and severe autonomic nervous system disorder.

**Diphtheria** is a serious respiratory disease that spreads when germs pass from an infected person to the nose or throat of others. It causes a thick coating in the nose, throat, or airway which can lead to breathing problems, heart failure, paralysis, or even death.

I understand that Td (Tetanus, Diphtheria) vaccine can protect me against these two serious diseases which are all caused by bacteria and are spread from person to person or through cuts, scratches, or wounds.

**TETANUS, DIPHTHERIA, PERTUSSIS (Tdap offered)**

**Tetanus (Lockjaw)** is a serious disease that is caused by a germ that enters the body through a cut or wound. It causes serious, painful spasms of all muscles and can lead to "locking" of the jaw which prevents one from opening his/her mouth or swallow and severe autonomic nervous system disorder.

**Diphtheria** is a serious respiratory disease that spreads when germs pass from an infected person to the nose or throat of others. It causes a thick coating in the nose, throat, or airway which can lead to breathing problems, heart failure, paralysis, or even death.

**Pertussis (Whooping Cough)** causes, among adults as well as children, severe coughing spells, vomiting, and disturbed sleep, and it can lead to weight loss, incontinence, rib fractures, fainting spells, pneumonia, and hospitalization in some cases.

I understand that Tdap (Tetanus, Diphtheria, and pertussis) vaccine can protect me against these three serious diseases which are all caused by bacteria and are spread from person to person or through cuts, scratches, or wounds.



VACCINE DECLINATION FORM

Table with 4 columns: Print Name, D.O.B., DEPT., e-raider #

I understand that results of my blood-work indicate I am not protected against the following disease (s) or infections(s). I am aware that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the following disease or infection:

- Measles, Mumps, Rubella
Varicella (Chickenpox)
Tetanus, Diphtheria
Tetanus, Diphtheria, Pertussis

I am aware that having the vaccine(s) intended to protect me against the disease(s)/infections(s) noted above has been recommended.

I further understand that if I contract the disease/infection, I may spread it to my patients, other healthcare workers, and/or my family. I may also be restricted from working with certain patient populations. If applicable, my supervisor and Infection Control Chairperson may be notified of these restrictions.

I have received education about the effectiveness of the vaccine and its potential adverse reactions and have been provided an information sheet which includes details about the disease/infection for which the vaccination (s) were recommended.

However, despite the risk of acquiring the disease/infections, I decline the Vaccination(s) at this time.

I understand that by declining this vaccine(s), I continue to be at risk of acquiring the serious disease(s)/infections(s) noted above and would be required to report any developing signs or symptoms of this specific disease/infection.

In the future, if I want to be vaccinated, I can opt to receive the vaccination at no cost to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

For office use only:

Check applicable boxes:

- Vaccine declined (specify):
Previously had the vaccine - proof or documentation not provided
Other reason for declination, please specify:

Does this employee have:

- 1) Natural antibodies [ ] yes [ ] no [ ] unknown
2) Medical contraindication to immunizations [ ] yes [ ] no