CaroMont Health

Flu Medical Declination Form

PLEASE PRINT THE FOLLOWING INFORMATION:

Name: _____ Date of Birth: ____/____/____

Phone: _____ Last 4 of Soc.Sec. Number_____

Supervisor/Manager: _____ Department: _____

Physician Name: _____ Physician Phone No.:_____

Dear Physician:

CaroMont Health requires influenza vaccination similar to other required vaccinations such as MMR and varicella. The influenza vaccination has been recommended for healthcare workers because it has been shown to be effective in reducing the incidences of influenza in inpatient populations. Influenza vaccination has also been recommended in pregnancy by the Centers for Disease Control to protect pregnant women (who are at increased risk of severe disease) and to protect the baby after it is born.

The above named person is requesting to decline this vaccination requirement. A Medical Declination from influenza vaccination is allowed for certain recognized contraindications (CDC MMWR Early Release 2011; Vol. 60.) Available online:
https://www.cdc.gov/mmwr/volumes/65/rr/rr6505a1.htm?s_cid=rr6505a1_w
https://www.cdc.gov/mmwr/pdf/wk/mm60e0818.pdf

Please complete the form below. Should you have any questions, please contact CaroMont Health Employee Health Services at (704) 834–2179

Thank you.

The above person should not be immunized for influenza for the following reasons (Please check all that apply.):

☐ History of previous allergic reaction or documented allergy testing to indicate an immediate hypersensitivity reaction to the influenza vaccine or a component of the vaccine. Please provide and attach a detailed narrative that describes the event.

☐ History of Guilain-Barre Syndrome within six weeks of receiving a previous vaccine. Please provide and attach a detailed narrative that describes the event.

☐ Other – Please provide this information in a separate narrative that describes the exception in detail (these requests will be reviewed on a case-by-case basis).

I certify that _____ has the above contraindication and request a Medical Declination from the influenza vaccination.

Physician Signature: _____ Date: _____

(Note: Signature Stamp Not Acceptable)

Physician Medical License No.: _____

PLEASE FAX, E-MAIL OR MAIL THIS TO
CaroMont Employee Health Services
2555 Court Drive, Suite 120
Gastonia, N.C. 28054
Office (704) 834-2179
Fax (704) 834- 2550
Kanchan.Dibert@Caromonthealth.org

DESIGNATED OFFICE USE ONLY:
Medical Exception Approved on:
____/____/____

Medical Staff Signature:
_____