Purdue University Influenza Vaccination Policy
Influenza Vaccination Declination Form

For use by faculty, staff and students on the West Lafayette campus.

I acknowledge I am aware of the following facts regarding influenza:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes;
- Influenza virus shedding may occur in individuals for up to 24 hours before symptoms begin, increasing the risk of transmission to others;
- Some people with influenza have no symptoms, increasing the risk of transmission to others;
- Influenza virus changes often, making annual vaccination necessary;
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease;
- I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for anyone over the age of 6 months in order to prevent infection from and transmission of influenza and its complications, including death, to my coworkers, my family and community;
- I understand that getting vaccinated myself may also protect people around me, including those who are more vulnerable to serious flu illness (i.e. infants, young children, older adults and individuals with certain chronic health conditions);
- I acknowledge that by declining the vaccine that I am more susceptible to the illness; and
- I understand the CDC recommends influenza vaccination, but in the context of the COVID-19 pandemic, states it is even more important in order to reduce illnesses and preserve scarce health care resources.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if the vaccine is available. I have read and fully understand the information on this declination form. I freely and voluntarily assume all risks of my decision to decline vaccination.

I decline vaccination for the following reason(s). Please check all that apply.

☐ My philosophical or religious beliefs prohibit vaccination.

☐ I have an allergy or medical contraindication to receiving the vaccine (physician statement attached)

Print Name ___________________________________ PUID ________________

Signature ___________________________________ Date _____________________