

**Adult Correctional Health  
Influenza Vaccination Acknowledgment**

Adult Correctional Health recommends that I receive the influenza vaccination in order to protect myself, other staff members, and the patients we serve. I acknowledge that I am aware of the following:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended by CDC for me and all other healthcare workers to prevent influenza disease and its complications, including death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. Shedding the virus can spread influenza infection to patients and staff in this facility.
- If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
- I understand that the strains of virus that cause influenza infections change almost every year, which is why a different influenza vaccine is recommended each year.
- I cannot get influenza disease from the influenza vaccine.
- The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including patients, staff, my family, and my community.

**Influenza Vaccination Acceptance / Declination**

Please check one of the following:

- I accept the influenza vaccination offered by Adult Correctional Health.
- I decline the influenza vaccination offered by Adult Correctional Health because I have been or will be vaccinated by a provider of my choosing. I will provide verification by November 1 or will wear a surgical mask while in the jails until I provide verification.
- I decline the influenza vaccination at this time. I will wear a surgical mask while in the jails between November 1 and March 31. I understand that by declining this vaccine, I continue to be at risk of contracting influenza and/or exposing others. I understand that I may change my mind at any time and accept the influenza vaccination, if available. I acknowledge that I have read and fully understand the information on this form.

Printed Name \_\_\_\_\_

Job Title \_\_\_\_\_ Facility \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Distribution:** Original – Scanned copy to ACH Secretary  
Copy – Employee (upon request)