COVID-19 Vaccination Reporting Form

First Name (Print):_____ Last Name (Print): _____

VPCH policy requires staff to report updates regarding their COVID-19 vaccination status. This information is kept confidential and used only to satisfy required facility reporting to NHSN.

Have you received an updated COVID-19 vaccine? Updated vaccine released September 2023

❑ Yes ❑ No

Most recent COVID-19 vaccine dose date (Month & Year): _____

Manufacturer: _____

Signature: _____ Date: _____

COVID-19 Vaccination **Declination** Section.

Complete the following section only if you do **not** plan to receive an updated COVID-19 vaccine.

I understand that the Vermont Psychiatric Care Hospital (VPCH) recommends that I receive a COVID-19 vaccine to protect myself, patients, staff and others in the facility and surrounding community.

I acknowledge the following facts (please read and check each box)

- ❑ I understand that I can obtain the COVID-19 vaccine free of charge
- ❑ I understand that COVID-19 is a serious respiratory illness. The virus that causes COVID-19 has infected and killed millions of people and has caused many more hospitalizations. It is particularly dangerous to the patients in psychiatric care facilities and people with chronic conditions.
- ❑ If I become infected with COVID-19, even if my symptoms are mild or non-existent, I can spread the virus to others. Symptoms that are mild or non-existent in me can cause serious illness and death in others.
- ❑ I understand that the COVID-19 vaccine does **not** cause COVID-19.

Despite these facts, I have chosen to decline COVID-19 vaccination for the following reasons:

_____

_____

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Note: If you later change your mind and obtain vaccination against COVID-19, VPCH requires reporting of COVID-19 vaccination information to the infection control nurse (photo of vaccination card, documentation from healthcare provider, or state immunization registry record are required)

Influenza Vaccination Reporting Form

September 2024 through April 2025

Name (Print Clearly): _____

Vaccination Reporting Period: Influenza season 2024-2025

What is your role?

- ❑ State/VPCH employee
- ❑ Contracted personnel (travel staff)
- ❑ Independent practitioner (pharmacy)
- ❑ Student, volunteer, intern

Select/Circle one of the following:

1. **Yes,** I have received this season's influenza vaccine
   - ❑ At VPCH (Month & Year): _____
   - ❑ Off-site (Month & Year): _____
2. **No,** I have/will not receive this season's influenza vaccine

   What is your reason(s) for not receiving the vaccine?
   - ❑ Medical contraindication to flu vaccines
   - ❑ The vaccine is not easily available
   - ❑ Personal preference
   - ❑ Other, please explain: _____
3. Decline to provide information about vaccination status

Signature:_____ **Date:** _____

Complete the section below **ONLY** if you have **NOT** received the influenza vaccine or if you declined to provide information

Influenza Vaccination Declination Statement

My employer, VPCH, recommends that I receive influenza vaccination to protect myself, patients, staff, and others in the healthcare facility.

I acknowledge that I am aware of the following facts (please read and **check each box**):

- ❑ Influenza is a serious respiratory disease. Each year in the United States, influenza kills thousands of people and causes hundreds of thousands of hospitalizations.
- ❑ Influenza vaccination is recommended for me and all other healthcare personnel to protect our staff and our facility's patients from influenza, its complications, and death.
- ❑ If I contract influenza, I can shed the virus for 24 hours before any influenza symptoms appear. During the time I shed the virus, I can transmit influenza to patients and staff in this facility.
- ❑ If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread influenza to others. Symptoms that are mild or non-existent in me can cause serious illness and death in others.
- ❑ I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended every year.
- ❑ I understand that it is impossible to get influenza from influenza vaccine.
- ❑ The consequences of my refusal to be vaccinated could have life-threatening consequences for my health and the health of everyone with whom I have contact, including my coworkers and all patients in this healthcare facility.
- ❑ I understand that I can change my mind at any time and accept influenza vaccination.

I have read and fully understand the information on this Influenza Vaccination Declination Statement.

Signature_____ Date _____

The use of signed declination statements is a recommendation from the CDC and the Advisory Committee on Immunization Practices (ACIP) as an evidenced-based strategy to improve healthcare provider vaccination rates. For more information visit https://www.cdc.gov/flu/toolkit/long-term-care/plan.htm#best-practices or see the following document: Advisory Committee on Immunization Practices; Centers for Disease Control and Prevention (CDC). Immunization of health-care personnel: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep. 2011 Nov 25;60(RR-7):1-45. PMID: 22108587.