		Please check **ALL THAT APPLY**	
Name (please print)		☐ Holland Bloorview Employee	☐ Bloorview School
Department (if applicable)		☐ Student	☐ Volunteer
Date		☐ Family Leader	☐ Sodexo Employee
		☐ Contractor	
		☐ Kindercircle Employee	

Influenza Information

Influenza is a serious infection of the respiratory tract that causes sickness in millions of people every year. Influenza is spread from person to person by contact with respiratory secretions. Influenza affects all age groups and can lead to severe illness and increased absenteeism from school and work. If you do get influenza, you can be ill and off work for seven days or more. It can also result in other diseases such as pneumonia and can lead to hospitalization and death.

Holland Bloorview is committed to providing the best care for our patients and our employees, which is why we are strongly encouraging all staff to be immunized.

Here are some things to keep in mind:

- You cannot get influenza from the vaccine.
- If you are not immunized, you can be a carrier and spread severe illness to others including your family, the people you work with and our patients, even if you never get sick.
- Immunization can provide protection for the whole season against most influenza viruses.
- Side effects from the vaccine are generally mild, and may include a sore arm, mild fever and muscle aches and feeling tired for a day or two. For a full list of potential side effects please ask to read additional product information.
- Severe allergic reaction is extremely rare.
- The influenza virus usually changes each year which is why there is a different vaccine each year.
- This year's vaccine contains:
    - A/Guangdong-Maonan/SWL1536/2019 (H1N1)pdm09-like strain
    - A/Hong Kong/2671/2019 (H3N2)-like strain
    - B/Phuket/3073/2013-like strain
    - B/Washington/02/2019-like strain

IMPORTANT: IF YOU EXPERIENCE ANY OTHER SYMPTOM(S) WITHIN 7 DAYS OF VACCINATION-PLEASE SEEK APPROPRIATE MEDICAL ATTENTION AND ADVISE THE PHYSICIAN THAT YOU HAVE HAD THE INFLUENZA VACCINE AND REPORT BACK TO OCCUPATIONAL HEALTH, AND WELLNESS.

Vaccination Screening Questions

	No	Yes
Are you sick at this time with something more than a cold?		
Do you have a history of convulsions or a problem with the central nervous system (i.e. Epilepsy, Guillain Barre Syndrome)?		
Have you received any vaccines or injections in the last month (4 weeks)?		
Are you taking any steroids or other immunosuppressive treatments (i.e. cortisone, anti-cancer drugs, radiation, Warfarin, Dilantin or Theophylline)?		
Do you have drug allergies or have you had a reaction to drugs or medications in the past?		
Do you have a known sensitivity to neomycin/thimerosal (preservative found in some contact lens solutions and some vaccines)?		
Do you have a known sensitivity to formaldehyde, cetyltrimethylammonium bromide, polysorbate 80 or gentamicin (components of vaccine)?		
Have you had a reaction to immunizations in the past?		
Are you pregnant? If yes, how many weeks:		

Influenza Declaration Status

YES- I choose to be immunized against Influenza. (please check applicable option)

☐ I choose to be immunized by the Occupational Health and Wellness department at Holland Bloorview during the seasonal influenza campaign.

☐ I have been immunized **elsewhere** and have provided proof of my immunization.

I, _____have read and understand the general information about immunizations and specific information on the benefits and adverse reactions. I understand the Occupational Health and Wellness Department will use and/or disclose my vaccination status to my Manager and Public Health for the purpose reporting immunization rates for healthcare workers and for outbreak management processes.

Signature:_____

NO – I choose not to be immunized against influenza due to personal reasons

☐ I am choosing not to be immunized against influenza at this time. I understand that as part of Holland Bloorview's commitment to preventing the spread of infectious diseases for the protection of clients and employees, if I choose not to receive the influenza vaccine I have the option to wear a face mask in designated areas in the hospital during influenza season. I understand that in the event of an influenza outbreak, the following will take place: All staff, students and volunteers who have not been vaccinated with the current season's vaccine and who perform work on the inpatient care area(s) which is experiencing an outbreak will not be allowed to work/volunteer and may not return to work to the area until one of the events listed below occurs (whichever occurs first):

1. The outbreak is declared over, or
2. The antiviral medication is started (volunteers/students excluded)
3. 14 days have passed since the staff member or volunteer has been given the influenza vaccine.

Reason for not getting vaccinated (Optional): _____

NO – I am unable to be vaccinated for medical reasons

☐ I am unable to be immunized this year because my doctor has confirmed that it is medically contraindicated. *I agree to provide documentation confirming this*. I understand that during influenza season, I have the option to wear a facemask in areas designated by the hospital. I understand that in the event of an influenza outbreak, the following will take place: All staff and volunteers who have not been vaccinated with the current season's vaccine and who perform work on the inpatient care areas which are experiencing an outbreak will not be allowed to work/volunteer and may not return to work to the area until one of the events listed below occurs (whichever occurs first):

1. The outbreak is declared over, or
2. The antiviral medication is started (volunteers /students excluded)

I,_____have read and understand the general information about immunizations and specific information on its benefits. I understand that the Occupational Health and Wellness Department will use and/or disclose my vaccination status to my Manager and Public Health for the purpose of reporting immunization rates for healthcare workers and for outbreak management processes.

Signature:_____

Occupational Health, Safety and Wellness use ONLY						
Date/Time	**Vaccine**	**Lot#**	**Dose**	**Route**	**Deltoid**	**Administered by**
	☐ FluLavel Tetra ☐ Fluzone Quad ☐		0.5 mL	IM	☐Left ☐Right	