



**Lutheran
HealthCare**

**Evidence of Compliance
Influenza Vaccination Requirements**

Name _____ Date of Birth (DOB) _____

Department: _____ CATEGORY: Employee (Number: _____)

Title: _____

Affiliate:

Volunteers

Agency/Contract

Students/Trainees

Voluntary Medical/Dental Staff

Section A. Influenza Vaccine Administration

Vaccine: Seasonal Influenza H1N1

Administration Site: Left Arm Right Arm Nasal

Dosage: _____ Manufacturer and Lot No: _____

Administered By: _____ Date: _____ Time: _____
(signature required)

Section B. Medical Exemption Statement

Medical exemptions for influenza vaccination should be based on contraindications and precautions determined by the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP), Public Health Services, U.S. Department of Health and Human Services, published in the Centers for Disease Control and Prevention publication, the Morbidity and Mortality Weekly Report.

Medical contraindications and precautions recognized by the Advisory Committee on Immunization Practices (ACIP) will be permitted as exemptions for immunization. These ACIP contraindications and precautions are to guide determinations made by individual practitioners to the existence of a medical exemption.

Criteria for Exemption

Contraindications

Severe allergic reaction after a previous dose or to a vaccine component (e.g., eggs).

Precautions:

Current moderate or severe acute illness with or without fever (until symptoms have abated).

History of Guillain Barré Syndrome within 6 weeks of a previous influenza vaccination.

Section C. Authorized Provider

Name (Print) _____ Signature _____
(NYS licensed physician or nurse practitioner.)

NYS License Number _____ Date: _____

Address _____

Telephone _____

Please fax completed form to Occupational Health Services at 718-630-6503.

(Rev. 9/29/09)