ATTACHMENT A

Influenza Vaccination Acknowledgement and Exemption Form Request

To consider a request for exemption, this Acknowledgement and Exemption Form Request along with the required documentation must be submitted no later than October 1 for the upcoming Flu Season.

I understand that it is the policy of LG Health that all Health Care Personnel working at LG Health be immunized against influenza on an annual basis. Influenza vaccination is a requirement for working at LG Health or in any LG Health facility.

I acknowledge that I have read and understand the following facts:

- 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 for me and all other health care personnel to protect our patients, employees and families from influenza disease, its complications, and death.
- I am likely to be exposed to the influenza virus through the community or at work.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread the influenza disease to patients in this facility, to my colleagues, and family.
- If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
- I understand that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my not being vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including any patients, my coworkers, my family and my community.
- I understand that if I am granted an exemption, I will be required to wear a surgical mask within 6 feet of any person at all times while influenza virus is active in the community (as determined by LG Health).

Exemption Request

Despite these facts, I am requesting an exemption to the annual influenza immunization. I request an exemption to the influenza immunization requirements based on the following:

Medical Contraindication:
Indicate Reason: _____

MUST complete Attachment B

Religious Belief or Creed:
Indicate Reason: _____

MUST complete Attachment C

I understand that my failure to submit acceptable medical documentation or provide a statement that supports my request for exemption for religious reasons may result in my request for an exemption being denied.

I understand that my request for an exemption will be reviewed, and I will be contacted with a decision regarding my exemption request, and that there will be a process for review that I may request if my exemption is denied.

I understand that in order to maintain a safe work environment for patients and staff:

(i) my manager and/or supervisor will be notified of my exemption;
(ii) I will be required to wear a surgical mask when working within 6 feet of any person, while influenza is active within the community (as determined by LG Health);
(iii) I may be reassigned if working in a high risk area or I may need to conform to additional infection prevention and control measures while at work.

I consent to the release of this request, including any supporting documentation, to all such representatives of LG Health, on a need-to-know basis, in order for the representatives to carry out their duties and to act on my request for an exemption.

Signature: _____ Date: _____

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

Department: _____ Manager: _____

Position: _____ Shift: _____

ATTACHMENT B

Request for Medical Exemption from Influenza Vaccination

As a patient safety and health care personnel safety initiative, LG Health is requiring annual influenza vaccination for Health Care Personnel at LG Health entities. This is similar to other vaccinations that the health care organization requires as a condition of employment. For decades, influenza vaccination has been recommended for health care personnel and has been shown to be effective in protecting patients from influenza illness and complications related to influenza. Increasingly, national professional, health care, and infection prevention organizations are strongly recommending that health care organizations require annual influenza vaccination to protect the health and safety of patients, employees, patient and employee family members, and the community as a whole from influenza infection.

Medical exemption from influenza vaccination is allowed for recognized contraindications, see CDC at http://www.cdc.gov/flu/protect/whoshouldvax.htm.

Please complete the form below to request medical exemption for your patient. If you have any questions, please contact Bobbi Jo Hurst, Employee and Student Health Manager, (717) 544-2331.

NAME OF PATIENT: _____ Employee/Badge #: _____

My patient should not be vaccinated against influenza for the following reason(s):

- **O** Severe allergic reactions to eggs (defined as developing hives, swelling of the lips or tongue or difficulty breathing; does not include gastro-intestinal symptoms). **Note:** the amount of egg protein in influenza vaccines is extremely small. People who can tolerate eating food prepared with eggs, such as baked goods, can generally tolerate the influenza vaccine.
- **O** History of previous severe allergic reaction to the influenza vaccine or component of the vaccine (defined as developing hives, swelling of the lips or tongue, or difficulty breathing; does not include sore arm, local reaction, or subsequent upper respiratory tract infection).
- **O** History of Guillan-Barre syndrome within six weeks of receiving a previous vaccine.
- **O** Other: Describe: _____

This is a **O** Temporary Medical Condition

O Permanent Medical Condition

I certify that my patient has the above contraindications and request medical exemption from the influenza vaccine. I understand that I could be contacted for additional clarification.

Name of Physician (MD, DO): _____

Signature: _____

Signature stamps are <u>not</u> acceptable

Telephone #: _____

Forward completed form to Employee Health

FOR OFFICE USE ONLY

Received by Employee Health Services on the following date: _____

Reviewed by Employee Health Services on the following date: _____

Disposition:

Approved by: _____

Disapproved by: _____

Person requesting exemption notified on the following date: _____