

Dear Nursing Student,

Students in all health professions programs are required to be vaccinated against influenza, per the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for health care personnel. Health facilities expect students assigned there for clinical/practicum placements to show proof of having received an annual immunization for influenza.

The Nursing Department at Heritage University is requesting documentation of the 2018-2019 influenza vaccine from all nursing students.

**This form allows your provider to document either administration of influenza vaccine, or rationale for medical contraindication. Please have your health care provider (MD, ARNP, or PA only) complete section 1 OR 2, AND 3. A note on letterhead or chart prints-out will substitute for documentation of influenza vaccine, but this form MUST be submitted for waiver requests.**

**Section 1:**

Patient Name:	_____	DOB:	____/____/____
	<small>Last, First</small>		<small>MO DAY YR</small>
Date influenza vaccine received:	Month: _____	Day: _____	Year: _____
Type of Vaccine:	Injected/Inactivated: _____	or Live/Intranasal: _____	or Recombinant: _____

**OR**

**Section 2:**

**WAIVERS:** If you have a MEDICAL reason for not being able to receive the flu vaccine (such as history of a **severe reaction** to a prior dose of influenza vaccine, or vaccine components), then this will need to be documented by a provider (MD, ARNP, or PA) and you must return this completed form. **PLEASE NOTE: Egg allergy itself is no longer a contraindication for most adults. Egg-free vaccine may be given to these individuals.**

Patient Name:	_____	DOB:	____/____/____
	<small>Last, First</small>		<small>MO DAY YR</small>

The above named patient has the following medical reason for declining influenza vaccination this year:  
\_\_\_\_\_

I have verified this is a valid medical contraindication per the stated CDC guidelines referenced at:  
<http://www.cdc.gov/flu/professionals/vaccination/vax-summary.htm>

**AND**

**Section 3:**

**Required:**

Signature:	_____	(MD, PA, ARNP)
Printed Name:	_____	
Phone number:	_____	Date: _____

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Return this form, **signed and dated by provider**, to Melissa Sanchez, Administrative Coordinator, Department of Nursing, Heritage University.