COVID-19 Vaccination attestation

Reporting period: 2025-2026 Respiratory Virus Season

Name (Print Clearly): _____

Please select one of the following that **best** describes your role at VPCH:

- ❑ State of Vermont employee (SoV)
- ❑ Licensed independent provider (travel staff, medical staff, pharmacist
- ❑ Student, intern, or volunteer
- ❑ Other (please describe): _____

Do you have a valid medical contra-indication to receiving COVID-19 vaccines?

❑ No ❑ Yes

Have you received **any** dose(s) of any COVID-19 vaccine?

❑ No ❑ Yes

Date of most recent COVID-19 vaccine (Month & Year): _____

Signature: _____ Date: _____

Please report (email or in writing) any additional future COVID-19 vaccines to elizabeth.saxton@vermont.gov. Information is used for required reporting to NHSN for inpatient psychiatric facilities only. Proof, or official documentation of vaccine history or medical contraindication is **not** required.

Influenza Vaccination Reporting Form

Name (Print Clearly): _____

Vaccination Reporting Period: Influenza season September 2025- April 2026

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.