

PLEASE RETURN COMPLETED FORM TO CAREGIVER (EMPLOYEE) HEALTH SERVICES

COVID-19 Declination Form 2025-2026

Providence St. Joseph Health and its family of organizations requests caregivers participate in the COVID-19 vaccination process by either being vaccinated or completing a written declination.

LEGAL NAME: _____ DOB: _____ EMPLOYEE ID# _____

CAMPUS/SITE: _____ DEPT: _____ PHONE: _____

IF **NOT** EMPLOYED BY PROVIDENCE, CHECK ONE:

☐ Medical Provider ☐ Volunteer ☐ Agency/Contractor ☐ Student ☐ Other _____

I AM DECLINING A COVID-19 VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- COVID-19 can cause severe illness or death and you can continue to have long-term health issues after COVID-19 infection. The level of protection people get from a COVID-19 infection may vary depending on how mild or severe their illness was, the time since their infection, and their age.
- Getting a COVID-19 vaccine can provide added protection for people who have already had COVID-19.
- Getting a COVID-19 vaccine is a safer and more dependable way to build immunity than getting sick with COVID-19, as vaccination causes a more predictable immune response than an infection with the virus that causes COVID-19.
- COVID-19 vaccines are recommended for healthcare workers because of the potential for workplace exposure and because of the vulnerability of the patients and residents they care for.
- COVID-19 vaccines help prevent severe illness, hospitalization, and death. Unvaccinated people are more likely to get COVID-19 and much more likely to be hospitalized and die from COVID-19, compared to people who are up to date with their COVID-19 vaccinations.
- COVID-19 vaccination is recommended for people who are pregnant, breastfeeding, or trying to get pregnant, as well as people who might become pregnant in the future. COVID-19 vaccination during pregnancy helps prevent severe illness and death and helps protect babies younger than 6 months old from hospitalization.
- Persons infected with COVID-19 virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, some of whom may be at higher risk for complications from COVID-19.
- Some people are more likely than others to get very sick if they get COVID-19. This includes people who are older, are immunocompromised, have certain disabilities, or have underlying health conditions.
- Side effects after a COVID-19 vaccination tend to be mild, temporary, and like those experienced after routine vaccinations. Serious side effects are rare but may occur.
- I understand I must follow all current infection prevention policies and procedures for my location, such as masking, to limit the possibility of transmission of the virus.
- I understand that I can change my mind and agree to provide my vaccination record if I receive the vaccine in the future.

I am declining the COVID-19 vaccine because of:

☐ My Licensed independent practitioner-documented allergy or medical contraindication to the components of the vaccine

☐ My religious beliefs, including my sincerely held ethical or moral beliefs

ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM

I, _____, agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the **legal equivalent** of my manual/handwritten signature and I consent to be legally bound to this agreement.

Signature: _____

Date: _____

CAREGIVER HEALTH SERVICES

PLEASE RETURN COMPLETED FORM TO CAREGIVER (EMPLOYEE) HEALTH SERVICES

COVID-19 Declination Form 2025-2026 - MINOR

Providence St. Joseph Health and its family of organizations requests caregivers participate in the COVID-19 vaccination process by either being vaccinated or completing a written declination.

LEGAL NAME: _____ DOB: _____ EMPLOYEE ID# _____

CAMPUS/SITE: _____ DEPT: _____ PHONE: _____

PARENT/LEGAL GUARDIAN NAME: _____ P/LG PHONE #: _____

IF **NOT** EMPLOYED BY PROVIDENCE, CHECK ONE:

☐ Medical Provider ☐ Volunteer ☐ Agency/Contractor ☐ Student ☐ Other _____

I AM DECLINING A COVID-19 VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- COVID-19 can cause severe illness or death and you can continue to have long-term health issues after COVID-19 infection. The level of protection people get from a COVID-19 infection may vary depending on how mild or severe their illness was, the time since their infection, and their age.
- Getting a COVID-19 vaccine can provide added protection for people who have already had COVID-19.
- Getting a COVID-19 vaccine is a safer and more dependable way to build immunity than getting sick with COVID-19, as vaccination causes a more predictable immune response than an infection with the virus that causes COVID-19.
- COVID-19 vaccines are recommended for healthcare workers because of the potential for workplace exposure and because of the vulnerability of the patients and residents they care for.
- COVID-19 vaccines help prevent severe illness, hospitalization, and death. Unvaccinated people are more likely to get COVID-19 and much more likely to be hospitalized and die from COVID-19, compared to people who are up to date with their COVID-19 vaccinations.
- COVID-19 vaccination is recommended for people who are pregnant, breastfeeding, or trying to get pregnant, as well as people who might become pregnant in the future. COVID-19 vaccination during pregnancy helps prevent severe illness and death and helps protect babies younger than 6 months old from hospitalization.
- Persons infected with COVID-19 virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, some of whom may be at higher risk for complications from COVID-19.
- Some people are more likely than others to get very sick if they get COVID-19. This includes people who are older, are immunocompromised, have certain disabilities, or have underlying health conditions.
- Side effects after a COVID-19 vaccination tend to be mild, temporary, and like those experienced after routine vaccinations. Serious side effects are rare but may occur.
- I understand I must follow all current infection prevention policies and procedures for my location, such as masking, to limit the possibility of transmission of the virus.
- I understand that I can change my mind and agree to provide my vaccination record if I receive the vaccine in the future.

I am declining the COVID-19 vaccine because of:

☐ My Licensed independent practitioner-documented allergy or medical contraindication to the components of the vaccine

☐ My religious beliefs, including my sincerely held ethical or moral beliefs

ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM

I, _____, agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the **legal equivalent** of my manual/handwritten signature and I consent to be legally bound to this agreement.

CG Signature: _____

Date: _____

Parent/Legal Guardian Signature: _____

Date: _____

Seasonal Influenza Declination Form 2025-2026

Providence and its family of organizations offers the influenza vaccine free of charge to caregivers, volunteers, students, employed & non-employed providers, and contracted employees in accordance with the annual CDC recommendations. By being vaccinated, you are protecting yourself, your patients, your family, and the community.

NAME: _____ DOB: _____ EMPLOYEE ID# _____

CAMPUS/SITE: _____ DEPT: _____ PHONE: _____

IF **NOT** EMPLOYED BY PROVIDENCE (Check one):

☐ Licensed Practitioner ☐ Volunteer ☐ Contractor ☐ Student ☐ Other

I AM DECLINING THE INFLUENZA VACCINE (FLU SHOT). I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED THE FOLLOWING INFORMATION:

- Influenza is a serious respiratory disease that millions of people get every year. Hundreds of thousands are hospitalized, and thousands to tens of thousands die from flu-related causes. (2)
- Influenza vaccination is recommended for me and all healthcare workers to protect our patients from influenza disease, its complications, and death. (3)
- People infected with influenza virus, including those who are pre-symptomatic, can transmit the virus to coworkers, family members, and patients, some of whom may be at higher risk for complications from influenza. (3)
- Influenza vaccination is the most important measure to prevent seasonal influenza infection and the resulting potential complications for staff, their families, our patients and co-workers. (3)
- Influenza vaccination is recommended every year because immune protection declines over time and the virus is constantly changing. (4)
- The influenza vaccine contains inactivated virus or virus proteins which means it is not infectious therefore you cannot get influenza (the Flu) from the vaccine. (1)
- Side effects of the vaccine are usually mild and of short duration. (1)

- I understand the vaccine offered to me through Caregiver Health Services is preservative and latex free. An egg-free version of the vaccine may also be available, check with your local Caregiver Health office.
- I understand that I can change my mind and accept the vaccination at any time during the campaign, usually September through March, and through June if supplies are available.
- I understand I must follow any masking requirements in my ministry or region and commit to doing so.

I AM DECLINING THE INFLUENZA VACCINE (FLU SHOT) BECAUSE OF:

☐ As an accommodation for my documented medical condition.

☐ My religious or my sincerely held ethical or moral beliefs.

I, _____, agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the **legal equivalent** of my manual/handwritten signature and I consent to be legally bound to this agreement.

Signature: _____

Date: _____

References:

1. <https://www.cdc.gov/flu/vaccine-safety/index.html>
2. <https://www.cdc.gov/flu-burden/php/data-vis/2024-2025.html>
3. <https://www.cdc.gov/flu/hcp/infection-control/healthcare-settings.html>
4. https://www.cdc.gov/flu/vaccines/keyfacts.html#cdc_generic_section_5-vaccine-match

Seasonal Influenza Attestation Form 2025-2026

Providence and its family of organizations offers the influenza vaccine free of charge to caregivers, volunteers, students, employed & non-employed providers, and contracted employees in accordance with the annual CDC recommendations. By being vaccinated, you are protecting yourself, your patients, your family, and the community.

NAME: _____ DOB: _____ EMPLOYEE ID# _____

CAMPUS/SITE: _____ DEPT: _____ PHONE: _____

IF **NOT** EMPLOYED BY PROVIDENCE (Check one):

☐ Licensed Practitioner ☐ Volunteer ☐ Contractor ☐ Student ☐ Other

ATTESTATION: I attest I have received my influenza vaccine elsewhere for the 2025-2026 season.

Where was it received? _____

Who provided it? _____

Vaccine Type?

☐ Influenza ☐ Influenza - Egg Free ☐ Influenza – High Dose ☐ Influenza - FluMist

Date of Vaccination: _____

By typing your name on the line below, you certify that (i) you are the individual completing the form; (ii) all information entered on this form is true and accurate to the best of your knowledge; (iii) you agree with all terms and conditions as listed on this form; and (iv) you consent to typing your name as the means of providing your signature electronically and that such electronic signature is valid.

Vaccination must have taken place between August 1st 2025, and March 31st, 2026. Any misrepresentation in providing vaccination information in the Influenza Attestation of Vaccination Received Elsewhere may result in disciplinary action including and up to termination of employment. The information provided in support of my Influenza Vaccination Received Elsewhere is truthful and accurate. Providence St. Joseph Health reserves the right to request appropriate and/or legal documentation reflecting the proof of my Influenza Vaccination Received Elsewhere.

Signature: _____

Date: _____