AccuCare
HOME HEALTH SERVICES, INC
Nurturing support, when you need it, where you need it.

Influenza Form

Last Name First Name Middle Name	Date of Birth
Address	Age: _____ **Gender**: Male Female
City State Zip code	Telephone #

Choose 1

A. I DECLINE

I DECLINE to be vaccinated against the influenza virus. I have had the opportunity to be vaccinated, but refused. I accept responsibility for my declination and risk of exposure. I agree to always wear a face mask provided to me by Accucare Home Health Services while caring for my patient throughout the Flu season.

Signature_____ Print Name: _____

Date_____

B. I HAD THE FLU SHOT THIS SEASON (to be filled out by your Dr only.)

Date administered	Vaccine	Dose /Route/Site	Lot #,manufacturer & exp date	Name and Title
Date: _____	Seasonal Influenza	Dose: 0.5ml Route: IM Site: RD/LD	Lot#_____ Exp date_____ manufacturer_____	Name_____ Signature_____ Title_____ License # _____