



SCHOOL OF NURSING

INFLUENZA VACCINATION DECLINATION

Last Name: _____

First Name: _____

MU ID#: _____

Last 4 Digits of SSN: _____

Placement in the Nursing Program (circle one): BSN: Sophomore, Junior or Senior
RN to BSN, BA to BSN, and MSN

Date of Birth: _____

Gender: _____

Please check one of the following:

_____ I have had the influenza vaccine administered to me on _____ (date)

at _____ (physician/facility)

_____ I am declining the influenza vaccination due to medical contraindications.*

_____ Severe allergic reaction to eggs or other components of the influenza vaccine.

_____ History of Guillain-Barre Syndrome within six weeks after a previous influenza vaccination.

_____ Allergic to latex

_____ Fear of side effects

_____ Other {please specify} _____

Date: _____

Signature: _____

***Student must have documentation from a Health Care Provider of the above and must email the School of Nursing their documentation at musonstudentrecords@marshall.edu**