McLaren
PORT HURON

Student

ANNUAL Influenza Declaration

Student Name (Print): _____**Date of Birth**_____

School Affiliation (Print): _____ **Department**_____

Dates at our facility _____provide date(s) or date range

*** **Influenza vaccination is required for EVERY student over the age of 18 years, even if only in facility one day, unless there is documentation of a medical contraindication as listed below.**

****Please answer for current flu season of July 1 through June 30.**

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I have received my influenza vaccination on _____ (date) at _____ (where rec'd)

I have a medical contraindication to the influenza vaccination and am exempt from receiving an influenza vaccination**:**

1. Life threatening egg allergy _____
2. Severe influenza vaccine allergy _____
3. History - Guillain Barre Syndrome _____ (within 6 weeks of flu vaccine)

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By signing below, I am agreeing to the following statement:

- To the best of my knowledge, I have answered all of the above correctly.

Signature: _____ Date: _____

Please return to Employee Health
Fax: 810-985-2686