

SCHOOL DISTRICT OF HARTFORD JOINT #1

DECLINATION OF INFLUENZA VACCINE

I, _____, as an employee or spouse of an employee of the School District of Hartford Joint #1, understand the wellness program participation requirements.

I have discussed the benefits and risks of the influenza vaccine with my certified medical provider, and I choose not to receive an influenza vaccine during the school year beginning _____ and ending _____.

Signature of Employee/Spouse

Date

Printed Name of Certified Medical Provider

Date

Signature of Certified Medical Provider: _____