HOMES AND SENIORS SERVICES

Health Practitioners Influenza Vaccination Exclusion Form

I, _______________________________, provide consent for the release of information by the
(print name)
Physician regarding my inability to take the Influenza Vaccination and/or Tamiflu.

Signature: ____ Date: ___________________

Dear Physician,

Please provide complete information as indicated below. Please note that you will be reimbursed for any normal or customary fees for completing this form.

Patient Name: ____ Date of visit:_____________

Please complete the following:

Does this patient suffer from a medically recognized condition that prevents him/her from obtaining the Influenza vaccination? ☐ Yes ☐ No

If yes, what is the general nature of the medical condition? _____________________________

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What are the specific contra-indications of receiving the influenza vaccination for this patient?

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Is this patient able to take Tamiflu in the event of an Influenza outbreak? ☐ Yes ☐ No

If No, what are the specific medical reasons for not being able to take Tamiflu?

Are there any medically based concerns that would prevent this patient from wearing a protective mask during an outbreak in order to continue working? ☐ Yes ☐ No

If yes, what are the medical concerns? ____

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Physician Signature:___________________________________Date:____________________