APPENDIX A
Influenza Vaccination Medical Exemption Request Form

Print Name:_____ Associate Unit/Department:_____

Personal Health Care Provider:_____ Health Care Provider Phone Number:_____

I plan on working for Pulaski Memorial Hospital during
Influenza season (October 1-March 31): ☐ Yes   ☐ No

1. Have you received an influenza vaccination before: ☐ Yes   ☐ No
2. Did you receive an influenza vaccination injection or mist   ☐ Yes   ☐ No
3. When was the last time you were vaccinated, to the best of your recollection?
   Year of last influenza vaccination:_____ I have never been vaccinated: ☐
4. Do you have an egg allergy? If yes, check all that apply: ☐ Yes   ☐ No
   ☐ I do not eat eggs or egg products   ☐ Nausea/vomiting
   ☐ Severe allergic reaction   ☐ Rash and/or hives
   ☐ Tongue Swelling   ☐ Respiratory difficulty

   ☐ Other:_____

   a. Was your reaction severe enough to seek medical attention: ☐ Yes   ☐ No
   b. If yes, where was your reaction treated?

Healthcare Provider Office		Hospital	
Emergency Room		Urgent Care	
Home			

5. Do you have an allergy to other components of the vaccine, or   ☐ Yes   ☐ No
   other adverse reactions to the influence vaccination?
   a. If yes, identify components of the vaccination that you are allergic to:

Component Unknown		Thimerosal
Neomycin		Other:_____

   b. If yes, check all that apply:
   ☐ Anaphylactic reaction   ☐ Tongue Swelling   ☐ Rash and/or hives

   • Submit supporting documentation to Human Resources at 574-946-2128 (fax) or email to
     ohuber@pmhnet.com by September 15th annually.
   • Associates must annually submit documentation by their Primary Care Provider stating why
     associate should not receive the vaccine.
   • Associates will be notified in writing of the decisions of their medical exemption request.

Signature:_____   Date:_____

Pulaski
Memorial Hospital

09/23/2021