State of South Dakota
Exemption of Influenza Vaccination Form

Name:_____ **Employee Number:**_____

Department/Division:_____

An annual influenza vaccination is required for specific state personnel, as defined within the Mandatory Influenza Vaccination Policy. An exemption may be issued to any person who: (1) has a physician signed, documented medical contraindication to the influenza vaccination; or (2) adheres to a religious doctrine whose teachings are opposed to immunizations. If applicable, new hires must complete the form upon hire.

I acknowledge:

- Influenza is a serious respiratory disease. Each year thousands of deaths are caused by flu in the United States.
- Influenza vaccination is recommended for me and all other healthcare workers to protect patients, my family, and myself from influenza, its complications, and death.
- If I contract influenza, I can spread influenza to patients and my family 24 hours before the appearance of any influenza symptoms.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread influenza to others who may become seriously ill.
- I understand the vaccination against influenza is recommended each year because of varying strains of the virus and a decline in my immunity over time.
- My refusal to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including: patients, co-workers, my family, and my community.

I am declining influenza vaccination for the following reason(s):

☐ Medical exemption to influenza vaccination:

Signed: _____ Date: _____
(Licensed Physician per SDCL Chapter 36-4)

Printed Signature: _____

Address of Facility: _____

☐ I adhere to a religious doctrine whose teachings are opposed to immunizations

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By declining the influenza vaccination, I am required to wear a mask throughout the flu season, as determined by the South Dakota Department of Health. Refusing to wear a mask may lead to disciplinary action taken against me, up to and including suspension without pay or termination. At any time and if available, I may accept influenza vaccination if I change my decision.

Return this form to your supervisor no later than October 15. This form will be retained by the Bureau of Human Resources.

I have read and fully understand the information on this exemption form.

Signature:_____**Date:**_____

Program Manager:_____ **Date:**_____