Einstein
HEALTHCARE NETWORK

Influenza Vaccination Medical Accommodation Request Form

This form must be completed to request an accommodation from the mandatory influenza vaccination due to a **medical reason**. All forms will be kept confidential by Human Resources Department and the LiveWell Employee/Occupational Health Center.

Please fax completed forms by October 2, 2020
to LiveWell Employee Health at 215-456-1840.

(Please Print)

Name: _____ Employee #_____

Department: _____ Position: _____

Cell Number: _____ Email: _____
(Print Clearly) (Print Clearly)

Section I: Completed by Employee:

(Once all required information is submitted, employee may be contacted by LiveWell Employee Health.)

Please note that Einstein offers egg-free vaccine for *LiveWell physician approved* employees ages 18 – 64.

I am requesting a medical accommodation from the influenza (flu) vaccination requirement due to the following reason(s):

_____

_____

_____

_____

My signature below verifies that the information provided is accurate and true. I am also authorizing Einstein to review my past practices related to employment vaccinations and a Healthcare Provider from LiveWell Occupational Health to contact the Healthcare Provider in Section II for further discussion, clarification, and/or release of medical information related to request.

_____ _____/_____/_____

Employee Signature Date

Einstein HEALTHCARE NETWORK

Influenza Vaccination Medical Accommodation Request Form Verification Section

This form must be completed to request an accommodation from the mandatory influenza vaccination due to a **medical reason**. All forms will be kept confidential by Human Resources Department and the LiveWell Employee/Occupational Health Center.

Please fax completed forms to LiveWell Employee Health at 215-456-1840.

Section II: Healthcare Provider Statement MUST be attached for request to be considered and reviewed.

Employee Name: _____ Employee #_____
(Print Clearly)

I am recommending that the above individual **not receive** the influenza (flu) vaccine for one of the following reasons:

☐ Severe Allergic Reaction: Note date of this allergic reaction: Date ____/____/____

The individual has had a documented severe allergic reaction to the influenza (flu) vaccine.*

(check all symptoms that apply to above noted severe reaction)

☐ Hives ☐ Swelling of face, eyes or tongue ☐ Difficulty Breathing

☐ Heart Palpitations ☐ Other _____

*Severe Allergic Reaction *does not include sore arm, local reaction or subsequent upper respiratory tract infection.*

☐ The individual has a history of Guillain–Barré Syndrome that occurred within 6 weeks of receiving influenza (flu) vaccine. Date of flu vaccine administration: ____/____/____

Date symptoms started: ____/____/____ Specify Symptoms: _____

☐ Other reasons, please explain in detail: _____

_____

OR

☐ I recommend the individual noted above, **delay receiving** the influenza (flu) vaccine until ___/___/___

Reason(s) for this delay: _____

_____ _____ ___/___/___
Signature – Physician/Healthcare Provider Printed Name Date

_____ _____
Office Phone Number Office Address