North Central Health Care
Person centered. Outcome focused.

**TO: MVCC, Pine Crest, Housekeeping, Food Services, and Transportation** September 25, 2023

Dear NCHC Employee,

Getting vaccinations, including the influenza and Covid vaccinations, is an easy way to protect yourself, your family, friends, coworkers, and those we serve. The flu and Covid vaccinations are fast, affordable, and safe, and can prevent severe illness and even death. The Centers for Disease Control and Prevention recommends that all people 6 months of age and older get vaccinated against the flu and Covid.

**Based on the population of individuals that you serve and/or interact with at work, NCHC recommends that you receive both your influenza and Covid vaccinations.**

**NCHC's Vaccination Policy requires ALL employees to participate in the vaccination process by either receiving vaccinations OR completing the required declination form.** You must complete the vaccination process by Dec. 4, 2023. The information you need to participate in this year's vaccination process is included with this communication.

## Where Can I Get My Flu and/or Covid Vaccine?

Flu and Covid vaccines will be available this fall for you to receive easily at work!

**Vaccination Clinic Online Sign-up**

There are a few easy ways to get your flu and Covid vaccinations at **NO COST:**

- **Employee Vaccination Clinic -** Sign-up online at www.norcen.org/ForEmployees Appointments are available Oct. 11 – Nov. 15
- **In Your Department:** Designated nurses in direct care programs will be offering vaccinations. Please speak with your manager about your designated nurse vaccinator. Arrangements will be made directly with the nurse vaccinator in your department.

You may also choose to get your vaccination outside of NCHC, **at your expense**:

- **Employee Health & Wellness Center on Wausau Campus**
  Call 715.843.1256 to schedule your appointment. You must be covered by the NCHC Health Plan to utilize this option (please check availability of both vaccines when calling).
- **Primary Care Clinic of your choice**
- **Community Pharmacy locations -** Please contact your local pharmacy for information.

## What Do I Need to Do to BEFORE December 4, 2023?

1. Make an appointment and get your Flu and Covid vaccinations.
2. Complete the required forms.
3. Return forms to NCHC Employee Health.

Employees who do not participate in this process by Dec. 4 will be removed from the schedule.
*NOTE: If you are under the age of 18, you will need a parent or guardian to complete the forms and follow steps above.*

Instructions are provided on the back of this sheet to assist you with your required forms. ALL employees must complete and return the *Influenza Vaccination Employee Statement* and *TB Risk Assessment & Symptom Evaluation* forms. The *Declination of Vaccinations* form is only required if you are declining one or both vaccines.

If you have any questions, please contact NCHC Employee Health at 715.848.4396

# 2023 Vaccination Form Instructions

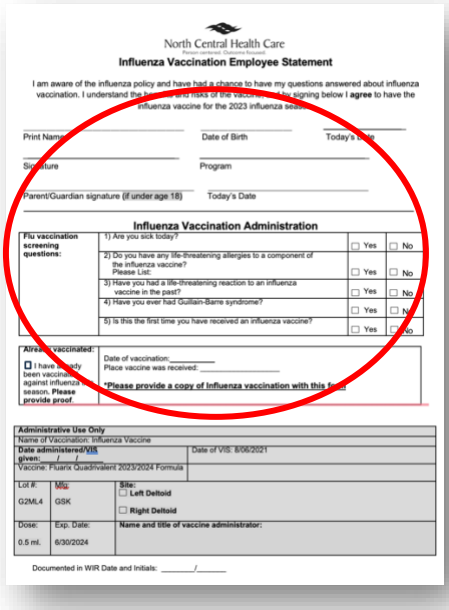
**For MVCC, Pine Crest, Housekeeping, Food Services, and Transportation Employees**

You should have 3 forms included in your packet that need to be **returned to NCHC Employee Health before December 4, 2023**.

1. Influenza Vaccination Employee Statement *(required to return)*
2. WI TB Risk Assessment and Symptom Evaluation *(required to return)*
3. Declination of Vaccines *(return only if declining one or both vaccines)*

**Influenza Vaccination Employee Statement**
**REQUIRED**

Complete all areas other than the gray Administrative Use Only box at bottom of form.



North Central Health Care

**Influenza Vaccination Employee Statement**

I am aware of the influenza policy and have had a chance to have my questions answered about influenza vaccination. I understand the benefits and risks of the vaccine. By signing below I **agree** to have the influenza vaccine for the 2023 influenza season.

Print Name: Date of Birth: Today's Date:

Signature: Program:

Parent/Guardian signature (if under age 18): Today's Date:

**Influenza Vaccination Administration**

| | | | |
|---|---|---|---|
| Flu vaccination screening questions: | 1) Are you sick today? | ☐ Yes | ☐ No |
| | 2) Do you have any life-threatening allergies to a component of the influenza vaccine? Please List: | ☐ Yes | ☐ No |
| | 3) Have you had a life-threatening reaction to an influenza vaccine in the past? | ☐ Yes | ☐ No |
| | 4) Have you ever had Guillain-Barre syndrome? | ☐ Yes | ☐ No |
| | 5) Is this the first time you have received an influenza vaccine? | ☐ Yes | ☐ No |

Already vaccinated: ☐ I have already been vaccinated against influenza this season. Please provide proof. Date of vaccination: Place vaccine was received: *Please provide a copy of Influenza vaccination with this form

**Administrative Use Only**

Name of Vaccination: Influenza Vaccine

Date administered/VIS given: Date of VIS: 8/06/2021

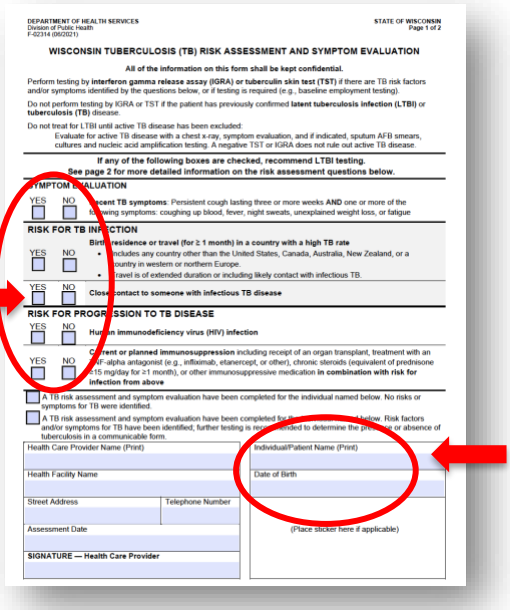
Vaccine: Fluarix Quadrivalent 2023/2024 Formula

| | | |
|---|---|---|
| Lot #: G2ML4 | Mfg: GSK | Site: ☐ Left Deltoid ☐ Right Deltoid |
| Dose: 0.5 mL | Exp. Date: 6/30/2024 | Name and title of vaccine administrator: |

Documented in WIR Date and Initials: _____/_____

**WI TB Risk Assessment and Symptom Evaluation**
**REQUIRED**

Complete the YES/NO questions only AND the Patient Name box in the lower right corner.



DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02314 (09/2021)

STATE OF WISCONSIN
Page 1 of 2

**WISCONSIN TUBERCULOSIS (TB) RISK ASSESSMENT AND SYMPTOM EVALUATION**

**All of the information on this form shall be kept confidential.**

Perform testing by **interferon gamma release assay (IGRA) or tuberculin skin test (TST)** if there are TB risk factors and/or symptoms identified by the questions below, or if testing is required (e.g., baseline employment testing).

Do not perform testing by IGRA or TST if the patient has previously confirmed **latent tuberculosis infection (LTBI)** or **tuberculosis (TB)** disease.

Do not treat for LTBI until active TB disease has been excluded:
Evaluate for active TB disease with a chest x-ray, symptom evaluation, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease.

**If any of the following boxes are checked, recommend LTBI testing.**
**See page 2 for more detailed information on the risk assessment questions below.**

**SYMPTOM EVALUATION**

YES NO **Recent TB symptoms**: Persistent cough lasting three or more weeks **AND** one or more of the following symptoms: coughing up blood, fever, night sweats, unexplained weight loss, or fatigue

**RISK FOR TB INFECTION**

YES NO **Birth, residence or travel (for ≥ 1 month) in a country with a high TB rate**
- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
- Travel is of extended duration or including likely contact with infectious TB.

YES NO **Close contact to someone with infectious TB disease**

**RISK FOR PROGRESSION TO TB DISEASE**

YES NO **Human immunodeficiency virus (HIV) infection**

YES NO **Current or planned immunosuppression** including receipt of an organ transplant, treatment with an anti-TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication **in combination with risk for infection from above**

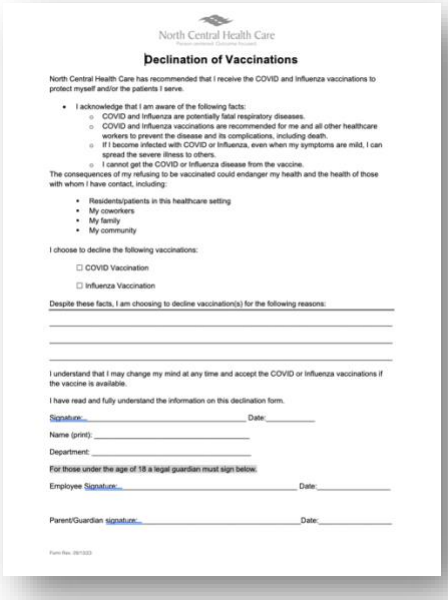
☐ A TB risk assessment and symptom evaluation have been completed for the individual named below. No risks or symptoms for TB were identified.

☐ A TB risk assessment and symptom evaluation have been completed for the individual named below. Risk factors and/or symptoms for TB have been identified, further testing is recommended to determine the presence or absence of tuberculosis in a communicable form.

| | |
|---|---|
| Health Care Provider Name (Print) | Individual/Patient Name (Print) |
| Health Facility Name | Date of Birth |
| Street Address / Telephone Number | (Place sticker here if applicable) |
| Assessment Date | |
| SIGNATURE — Health Care Provider | |

**Declination of Vaccinations**
**OPTIONAL**

ONLY complete this form if you are declining flu, Covid, or both vaccines. Fill out form completely.



North Central Health Care

**Declination of Vaccinations**

North Central Health Care has recommended that I receive the COVID and Influenza vaccinations to protect myself and/or the patients I serve.

- I acknowledge that I am aware of the following facts:
  - COVID and Influenza are potentially fatal respiratory diseases.
  - COVID and Influenza vaccinations are recommended for me and all other healthcare workers to prevent the disease and its complications, including death.
  - If I become infected with COVID or Influenza, even when my symptoms are mild, I can spread the severe illness to others.
  - I cannot get the COVID or Influenza disease from the vaccine.

The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:

- Residents/patients in this healthcare setting
- My coworkers
- My family
- My community

I choose to decline the following vaccinations:

☐ COVID Vaccination

☐ Influenza Vaccination

Despite these facts, I am choosing to decline vaccination(s) for the following reasons: _____

I understand that I may change my mind at any time and accept the COVID or Influenza vaccinations if the vaccine is available.

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

Signature: _____ Date: _____

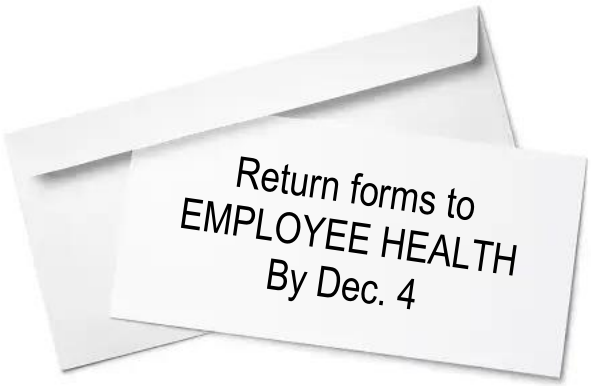
Name (print): _____

Department: _____

For those under the age of 18 a legal guardian must sign below:

Employee Signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____




**If you are declining one or both vaccines, you must complete and turn in 3 forms!**

**Employees who do not participate in the vaccination process and return forms by December 4, will be removed from the schedule.**

**Questions?** Talk with your manager or call Employee Health at 715.848.4396.

## How Can I Return Forms to Employee Health?

Return at your NCHC vaccination clinic appointment; OR

If you are receiving your vaccination in your department, return forms to your nurse vaccinator in the sealed envelope; OR

If you are receiving your vaccination outside NCHC, be sure to get a proof of vaccination from the provider and return with forms above to Employee Health in the sealed envelope via interoffice mail; OR

If you are declining all vaccines, return all forms to Employee Health via interoffice mail.

# WISCONSIN TUBERCULOSIS (TB) RISK ASSESSMENT AND SYMPTOM EVALUATION

**All of the information on this form shall be kept confidential.**

Perform testing by **interferon gamma release assay (IGRA) or tuberculin skin test (TST)** if there are TB risk factors and/or symptoms identified by the questions below, or if testing is required (e.g., baseline employment testing).

Do not perform testing by IGRA or TST if the patient has previously confirmed **latent tuberculosis infection (LTBI)** or **tuberculosis (TB)** disease.

Do not treat for LTBI until active TB disease has been excluded:

Evaluate for active TB disease with a chest x-ray, symptom evaluation, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease.

**If any of the following boxes are checked, recommend LTBI testing.**
**See page 2 for more detailed information on the risk assessment questions below.**

## SYMPTOM EVALUATION

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **Recent TB symptoms**: Persistent cough lasting three or more weeks **AND** one or more of the following symptoms: coughing up blood, fever, night sweats, unexplained weight loss, or fatigue |

## RISK FOR TB INFECTION

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **Birth, residence or travel (for ≥ 1 month) in a country with a high TB rate**<br>• Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.<br>• Travel is of extended duration or including likely contact with infectious TB. |
| ☐ | ☐ | **Close contact to someone with infectious TB disease** |

## RISK FOR PROGRESSION TO TB DISEASE

| YES | NO | |
|---|---|---|
| ☐ | ☐ | **Human immunodeficiency virus (HIV) infection** |
| ☐ | ☐ | **Current or planned immunosuppression** including receipt of an organ transplant, treatment with an TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication **in combination with risk for infection from above** |

☐ A TB risk assessment and symptom evaluation have been completed for the individual named below. No risks or symptoms for TB were identified.

☐ A TB risk assessment and symptom evaluation have been completed for the individual named below. Risk factors and/or symptoms for TB have been identified; further testing is recommended to determine the presence or absence of tuberculosis in a communicable form.

| Health Care Provider Name (Print) | |
|---|---|
| | |
| Health Facility Name | |
| | |
| Street Address | Telephone Number |
| | |
| Assessment Date | |
| | |
| **SIGNATURE — Health Care Provider** | |
| | |

| Individual/Patient Name (Print) |
|---|
| |
| Date of Birth |
| |
| (Place sticker here if applicable) |

## Risk Assessment Details

### USE OF THIS FORM

Use this form to assess individual risks for *M. tuberculosis* infection in adults (age ≥ 15 years).

### SYMPTOM EVALUATION

TB symptoms are listed on the front of this form. TB can occur anywhere in the body but the most common areas include; lungs, pleural space, lymph nodes and major organs such as heart, liver, spleen, kidney, eyes and skin. Clinical judgement should be accompanied by careful evaluation of patient history including residence in a country with high TB incidence, history of previous treatment for TB or LTBI and history of TB in the family.[4]

### RISK FOR TB INFECTION

**Birth, travel or residence (for ≥ 1 month) in a country with a high TB rate**

The World Health Organization (WHO) estimates TB incidence around the world in the *Global Tuberculosis Report*. Please see this report for countries with high TB rates, or call the Wisconsin Tuberculosis Program.[1, 5]

Leisure travel to most countries in the world poses little risk of TB infection. Prolonged stays or work in the health sector in an endemic country increase the risk of infection.[2]

**Close Contact to someone with infectious TB disease**

Infectious TB includes pulmonary, culture-positive disease and disease with pulmonary cavitation on radiograph. High Priority contacts include household members (1 in 3 chance of infection), children < 5 years of age and immunosuppressed individuals (HIV-positive, organ transplant, cancer, diabetes). Also consider those exposed for shorter duration in a more confined space (exam room, dormitory room, office or vehicle).[3]

**Other Risks**

Wisconsin has very low incidence of TB in healthcare, homeless, corrections, and long-term care settings. Higher-risk congregate settings occur in Alaska, California, Florida, Hawaii, New Jersey, New York, Texas, or Washington DC.[5]

Consult with local health departments for other locally identified high-risk groups: https://www.dhs.wisconsin.gov/lh-depts/counties.htm.

Consult with the Centers for Disease Control and Prevention (CDC) annual TB reports and the Wisconsin TB Program website for state and local epidemiology data. [6, 7, 8, 9]

### RISK FOR PROGRESSION TO TB DISEASE

Immune suppression is a risk factor for reactivation and progression to active TB disease. Immune suppression alone is not a risk for acquiring TB infection.

- LTBI treatment should be strongly considered in HIV-infected individuals; significant immune suppression can cause inaccuracy of diagnostic TB tests.
- LTBI treatment can be considered for other immune suppression (e.g., cancer, organ transplant, medications, or diabetes) **when in combination with risk for infection (see above).**

**References:**


1) World Health Organization Global Tuberculosis Report 2018. http://www.who.int/tb/publications/global_report/en/
2) Cobelens, F.G.J., et al (2000). Risk of infection with *Mycobacterium tuberculosis* in travelers to areas of high tuberculosis endemicity. *The Lancet*, 356, 461-465.
3) CDC. Guidelines for the investigation of contacts of persons with infectious tuberculosis: recommendations from the National Tuberculosis Controllers Association and CDC. *MMWR* 2005; 54(No. RR-15).
4) Lewinsohn, D. et al. Official American Thoracic Society/Infectious Diseases Society of America/CDC Clinical Practice Guidelines: Diagnosis of tuberculosis in adults and children. *Clinical Infectious Diseases*, 2017; 62(2):111-115.
5) Wisconsin Tuberculosis Program. https://www.dhs.wisconsin.gov/tb/index.htm. Phone: 608-261-6319.
6) CDC. Reported Tuberculosis in the United States. https://www.cdc.gov/tb/statistics/
7) CDC. Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health-care settings, 2005. *MMWR* 2005; 54(No. RR-17).
8) CDC. Tuberculosis screening, testing, and treatment of U.S. health care personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. *MMWR 2019: 68*(No. 19).
9) CDC. Prevention and control of tuberculosis in correctional facilities: Recommendations from CDC. *MMWR* 2006; 55(No. RR-9).

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# Influenza Vaccination Employee Statement

I am aware of the influenza policy and have had a chance to have my questions answered about influenza vaccination. I understand the benefits and risks of the vaccine, and by signing below I **agree** to have the influenza vaccine for the 2023 influenza season.

_____ _____ _____

Print Name | Date of Birth | Today's Date

_____ _____

Signature | Program

_____ _____

Parent/Guardian signature (if under age 18) | Today's Date

## Influenza Vaccination Administration

| | | | |
|---|---|---|---|
| **Flu vaccination screening questions:** | 1) Are you sick today? | ☐ Yes | ☐ No |
| | 2) Do you have any life-threatening allergies to a component of the influenza vaccine? Please List: | ☐ Yes | ☐ No |
| | 3) Have you had a life-threatening reaction to an influenza vaccine in the past? | ☐ Yes | ☐ No |
| | 4) Have you ever had Guillain-Barre syndrome? | ☐ Yes | ☐ No |
| | 5) Is this the first time you have received an influenza vaccine? | ☐ Yes | ☐ No |

| | |
|---|---|
| **Already vaccinated:** ☐ I have already been vaccinated against influenza this season**. Please provide proof**. | Date of vaccination:_____<br>Place vaccine was received: _____<br>***Please provide a copy of Influenza vaccination with this form** |

| **Administrative Use Only** | | |
|---|---|---|
| Name of Vaccination: Influenza Vaccine | | |
| **Date administered/VIS given:___/___/_____** | | Date of VIS: 8/06/2021 |
| Vaccine: Fluarix Quadrivalent 2023/2024 Formula | | |
| Lot #:<br>G2ML4 | Mfg:<br>GSK | **Site:**<br>☐ **Left Deltoid**<br>☐ **Right Deltoid** |
| Dose:<br>0.5 ml. | Exp. Date:<br>6/30/2024 | **Name and title of vaccine administrator:** |

Documented in WIR Date and Initials: _____/_____

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# Declination of Vaccinations

North Central Health Care has recommended that I receive the COVID and Influenza vaccinations to protect myself and/or the patients I serve.

- I acknowledge that I am aware of the following facts:
  - COVID and Influenza are potentially fatal respiratory diseases.
  - COVID and Influenza vaccinations are recommended for me and all other healthcare workers to prevent the disease and its complications, including death.
  - If I become infected with COVID or Influenza, even when my symptoms are mild, I can spread the severe illness to others.
  - I cannot get the COVID or Influenza disease from the vaccine.

The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:

- Residents/patients in this healthcare setting
- My coworkers
- My family
- My community

I choose to decline the following vaccinations:

☐ COVID Vaccination

☐ Influenza Vaccination

Despite these facts, I am choosing to decline vaccination(s) for the following reasons:

_____

_____

_____

I understand that I may change my mind at any time and accept the COVID or Influenza vaccinations if the vaccine is available.

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

Signature:_____ Date:_____

Name (print): _____

Department: _____

For those under the age of 18 a legal guardian must sign below.

Employee Signature:_____ Date:_____

Parent/Guardian signature:_____Date:_____