Flu Vaccination – Student Waiver
Nursing Student PASSPORT

Student Name: ____________________________
(Please print)

Date: _________________________________

1. I understand that if an outbreak of a vaccine-preventable disease occurs for which I have waived vaccination, I may be excluded from my educational rotation for the duration of the outbreak and/or threat of exposure for the benefit of myself, Intermountain’s staff, and the patients and families I am in contact with. I will not be allowed to complete my rotation until Intermountain Employee Health and Infection Control are satisfied there is no longer a risk of contracting or transmitting the vaccine-preventable disease.

2. I assume the risks of not having this vaccine and hereby release Intermountain Healthcare (IHCHS) from any liability arising from my failure to receive the vaccine.

_________________________________________  ______________________________________
Student Signature  Guardian Signature
(if student is a minor)

_________________________________________
IHCHS Facility

_________________________________________
IHCHS Witness