CORAL SPRINGS
REGIONAL INSTITUTE OF
PUBLIC SAFETY

"Commitment to Excellence"

ONLY REQUIRED DURING THE MONTHS OF OCTOBER THROUGH APRIL

Name: _____

Dear Student,

This letter is to inform you that with your participation in the EMT/Paramedic Program you will be required to complete hours for on-site Hospital Clinicals where you will be potentially coming into contact with sick people.

Below are facts about Influenza:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for all healthcare students and workers to prevent influenza disease and its complications, including death.
- If someone contracts Influenza, they will shed the virus for 24-48 hours before Influenza symptoms appear. Shedding the virus can spread influenza infection to patients and co-workers in this facility.
- If someone becomes infected with Influenza, even when their symptoms are mild, they can spread severe illness to others.
- The strains of the virus that cause Influenza infection change almost every year, which is why a different Influenza vaccine formula is recommended each year.
- A person cannot get the Influenza disease from the Influenza vaccine.
- The consequences of refusing to be vaccinated could endanger your health and the health of those with whom you've been in contact with, including:
    - **Patients and staff in this healthcare setting**
    - **Your family**
    - **Your community**

Broward Health and Tenet (Florida Medical Center) request that all participating in Hospital Clinicals at their facilities receive an annual Influenza vaccination in order to protect themselves, the staff and the patients they encounter.

Therefore you MUST be vaccinated between the months of October thru April (Flu Season). Proof of the vaccination is required. Below are the acceptable methods of providing proof:

1. Receipt from Walgreens, CVS, Publix etc… attached to this form
2. Paperwork from employer that provided the vaccine
3. Personal physician's office/Urgent care facility must fill out the below:

Date vaccine was given: _____ **Administered by:** _____

Provider Name (please print): _____ **Phone:** _____

Address: _____

Street **City** **State** **Zip**

Signature of MD/DO/ARNP: _____ **Date:** _____

License #:_____

*** If you are NOT vaccinated, you MUST have a valid medical reason and provide proof from a licensed physician.**