DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

OFFICE OF THE ASSISTANT SECRETARY

October 20, 2026

MEMORANDUM FOR ALL MAJCOM-FOA-DRU-FLDCOM-/CC DISTRIBUTION C

FROM: SAF/MR
1660 Air Force Pentagon
Washington, DC 20330-1660

SUBJECT: Guidance on Influenza Vaccination Exception to Policy

References: (a) SAF/MR Memorandum, *Annual Seasonal Influenza Vaccine Exception to Policy – United States Air Force Academy (USAFA)*, 29 June 2026 (hereby rescinded)
(b) SAF/MR Memorandum, *Annual Seasonal Influenza Vaccine Exception to Policy – Basic Military Training*, 26 June 2026 (hereby rescinded)
(c) SAF/MR Memorandum, *Annual Seasonal Influenza Vaccine Exception to Policy – Air Force and Space Force Technical Training*, 26 June 2026 (hereby rescinded)
(d) SAF/MR Memorandum, *Annual Seasonal Influenza Vaccine Exception to Policy – Child and Youth Programs Personnel*, 26 June 2026 (hereby rescinded)
(e) Under Secretary of War for Personnel and Readiness Memorandum, *Department of the Air Force Annual Seasonal Influenza Vaccine Exception to Policy,* 11 June 2026
(f) Under Secretary of War for Personnel and Readiness Memorandum, *Consolidated Annual Seasonal Influenza Vaccine Exception to Policy for Reserve Components,* 24 June 2026
(g) SAF/MR Memorandum, *Additional Guidance on Influenza Vaccination,* 11 May 2026
(h) Secretary of War Memorandum, *Updated Guidance on Influenza Vaccination,* 20 April 2026
(i) Deputy Secretary of Defense Memorandum, *Updated Policy on Seasonal Influenza Immunizations*, 29 May 2025
(j) DAFI 52-201, *Religious Freedom in the Department of the Air Force*, with DAFGM2026-01, 14 May 2026
(k) AFI 48-110_IP, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*
(l) DAFI 34-144, *Child and Youth Programs*
(m) Defense Health Agency Immunization Health Division: https://go.mil/vaccines
(n) Northern Hemisphere Influenza Vaccine Resource Center: https://go.mil/nhfluvaccine

This memorandum rescinds and replaces references (a) through (d) and outlines the Department of the Air Force's (DAF) implementation of OUSW(P&R) approved Annual

Seasonal Influenza Vaccine Exceptions to Policy (ETP) (references (e) and (f)) to require the following DAF personnel to receive the annual seasonal influenza vaccine:

- Recruits, training populations, and congregate living;
- Rapid Deployment Forces and "no-fail" missions;
- Deployed forces;
- Healthcare personnel;
- Civilian personnel employed in child development and youth services programs; and
- Air Mobility Command military personnel assigned as aircrew supporting United States Transportation Command taskings; enroute care personnel; and executive airlift personnel.

The annual influenza vaccination is a requirement for DAF personnel, including Active and Reserve Component Service members and civilian personnel in the six populations listed above, and as defined in attachment (1). Commanders may submit additional ETP requests outside the scope of the current six defined categories through their MAJCOM/SG to AF/SG; USW(P&R) is the approval authority for all ETP requests. It will be available to other members on a voluntary basis.

Air Reserve Components Application

In accordance with references (e) and (f), the annual influenza vaccination requirement applies to Air Force Reserve and Air National Guard (ARC) members serving in the six covered populations outlined above. Members may be vaccinated during scheduled duty periods or by a civilian provider, with documentation submitted for entry and verification in Aeromedical Services Information Management System (ASIMS) by the next Unit Training Assembly (UTA). Consistent with reference (i), an entire training day may not be dedicated to influenza vaccination, and members may not be placed in a paid duty status solely to receive the vaccine outside a scheduled duty period.

Implementation Timing

Implementation will differ by population and mission execution timelines. Vaccination requirements for the following populations are effective immediately and must be completed annually thereafter so long as the individual remains part of the covered population: recruits, training populations, and congregate living; healthcare personnel; and child and youth care center personnel. Vaccination for deploying forces will align with pre-deployment processing timelines. Vaccination for all other personnel covered under this guidance must be completed no later than 15 December annually.

Accessing Vaccinations and Funding

Unit commanders with personnel in each of the ETP categories must coordinate with their local military treatment facility (MTF) to secure adequate vaccine supply and schedule vaccinations aligned with their operational requirements. Requirements to obtain the annual

influenza vaccination and available funding for contract personnel vaccination are addressed in individual contracts.

Tracking and Reporting

Commanders shall ensure Airmen and Guardians fulfill individual medical readiness (IMR) requirements and monitor unit IMR status in accordance with AFI 10-250, *Individual Medical Readiness*. ASIMS will be used to monitor annual influenza requirements for service members as part of the IMR process.

- ETP category populations assigned to a specific unit or program (e.g., BMT, USAFA), that can systematically be grouped by Personnel Accounting System (PAS) Code, and/or Air/Space Force Specialty Code (AFSC/SFSC) will be automatically flagged for the annual influenza vaccine requirement in ASIMS.
- Deploying personnel (to include civilians and exercise deployers) will show due for their annual influenza vaccine in ASIMS when they are added to a deployment tasking in the Deployment Medical Clearance module. This requirement is subject to vaccine availability and Combatant Command theater entry policies, and expires upon redeployment. ETP category military personnel that are not captured by unit, PASCODE, or AFSC/SFSC (e.g., alert personnel, AFSOC, AMC/TRANSCOM personnel, and other "no-fail" mission assets) will be locally managed by the MTF and added to annual influenza vaccination ASIMS immunization exposure groups. Unit commanders will ensure the MTF is provided with a current and accurate roster of their ETP personnel.

Child and Youth Program (CYP) personnel annual influenza vaccine requirements will be managed and documented in accordance with reference (l). Local public health personnel will assess and validate vaccination records during routine sanitation inspections. ASIMS does not track these personnel, and vaccination records are kept in child and youth program personnel files.

MAJCOM/FLDCOM A1s/S1s and SGs will be tasked quarterly via Enterprise Task Management Software Solution (ETMS2) to provide data on vaccinations administered to the aggregated ETP population. Reports will be submitted using a standardized template in ETMS2 no later than 15 days following the close of each fiscal year quarter or as needed. At a minimum, reports will include, broken out by required population category and by component (Active/Reserve/Guard) and personnel type (military/civilian/contractor), total number of personnel requiring vaccination, number vaccinated/compliant, approved medical exemptions, approved religious accommodations, medical exemptions and religious accommodation requests, number non-compliant/refused, and compliance percentage understanding that counts will be subject to change given the inclusion of dynamic populations. Reports will be validated and certified by MAJCOM/FLDCOM A1s/S1s and SGs prior to submission. The first report will be due 15 November 2026.

Religious Accommodation and Medical Exemption Processes

Personnel (military and civilian) shall be afforded the opportunity to submit religious accommodation requests in accordance with reference (j) and applicable civilian personnel regulations, and medically indicated exemptions to the immunization in accordance with reference (k). Civilian employees shall submit requests for religious accommodations to their supervisor for processing in accordance with Title 29, Code of Federal Regulations, Part 1605. For civilian employees employed specifically in CYPs, per reference (l), the Mission Support Group commander or Space Delta Mission Support director is the decision authority for medical and religious immunization exemptions.

Personnel (military and civilian) with a properly submitted religious accommodation or medical exemption request shall be coded in ASIMS as temp/exempt with a date input for follow-up and considered in compliance for IMR and readiness-reporting purposes until a final determination is rendered. Members remain deployable unless otherwise directed by competent medical or command authority. Administrative or disciplinary action for refusal will not be initiated while a request is pending. Upon final disapproval of a request, the member will have an opportunity to comply with vaccination requirements.

Vaccination Refusals

For service members within the designated populations, vaccination is a requirement. Failure to comply may result in administrative or disciplinary action under the Uniform Code of Military Justice. Commanders should consider using the lowest appropriate level of discipline (per Appendix 2.1 of the *Manual for Courts-Martial,* United States (2024)) when evaluating options to address non-compliance, taking into consideration the circumstances of the non-compliance and the previous disciplinary record of the Airman or Guardian. Initial disposition authority is the first General Court-Martial Convening Authority in the chain of command with respect to service members who refuse to comply with this requirement.

For civilian employees in designated ETP positions (e.g., CYP staff), influenza vaccination is established as a condition of employment in accordance with reference (l). Supervisors will not initiate adverse action independently; non-compliance will be addressed through the servicing Civilian Personnel Section/Human Resources Office in coordination with Labor and Employee Relations. Actions involving bargaining-unit employees must comply with applicable collective bargaining agreement obligations, including any required union notification or negotiation. Civilian requests for religious or medical accommodation will be processed through civilian personnel/Equal Employment Opportunity (EEO) channels in accordance with applicable law and regulation. This guidance applies to both appropriated-fund and non-appropriated fund employees; supervisors will coordinate with the appropriate servicing civilian personnel authority.

My point of contact for this memo is Ms. Brandy Conway, brandy.conway.2@us.af.mil.

RICHARD L. ANDERSON
Assistant Secretary of the Air Force for
Manpower and Reserve Affairs

Attachments:
1. Defined Categories of ETP Personnel
2. Frequently Asked Questions

cc:
AF/A1
SF/S1
AF/SG
AF/RE
NGB/CF

Defined Categories of ETP Personnel

1. Recruits, Training Populations, and Congregate Living

a) **Definition.** All military personnel who are undergoing initial-entry, technical, or flying training, and all military personnel who reside in, are assigned to, or routinely operate within high-density congregate living or congregate-activity environments (those exceeding one person per 75 square feet as described in DA PAM 40-11, *Army Public Health Program*), where sustained close physical proximity, shared air, and shared facilities create a substantially elevated potential for influenza transmission.

b) **Settings/Conditions Creating Elevated Risk.** Open-bay and shared-room dormitory billeting; recruit/trainee housing; shared latrines, shower, and laundry facilities; congregate dining facilities; classroom and training-bay environments with sustained group instruction; physical training formations; and confinement/correctional facilities where personnel are housed in close quarters.
Note: Personnel assigned to single-occupancy dormitory rooms (to include permanent party) are excluded unless they are assigned to, or routinely perform duties in, a high-risk work environment or another population identified under paragraph 1(c).

c) **Population — Inclusive but Non-Exhaustive Enumeration.** This population includes (but is not limited to): (1) Basic Military Training (BMT) recruits; (2) Officer Training School (OTS), (3) Reserve Officer Training Corps (ROTC) field training, (4) United States Air Force Academy cadets and cadet candidates; (5) USAF and USSF technical training students; (6) undergraduate and graduate flying training students; (7) Military Training Instructors (MTIs); (8) Military Training Leaders (MTLs); (9) academic/flight commanders and instructional cadre in direct, sustained contact with trainees; (10) Unaccompanied Housing (UH) populations to include: dormitory managers and personnel residing in open-bay or shared billeting; and (11) personnel housed in confinement/correctional facilities.
Note: The MAJCOM/FLDCOM commander will retain discretion to evaluate and identify these populations based on local mission requirements, living conditions, operational exposure, and the specific needs of their assigned personnel. This determination should not rely on a blanket AF/USSF or MAJCOM/FLDCOM-wide roster, as commanders are best positioned to assess the risk and mission impact within their organizations.

d) **Identifying Authority and Tracking Mechanism.** Unit commanders will review their assigned populations and provide recommendations to the responsible Training Wing or Group commander for validation. Training Wing or Group commanders will identify personnel meeting the criteria in paragraphs 1(c), in coordination with the host-installation commander and supporting Military Treatment Facility (MTF)/immunization personnel. Validated personnel will be tracked in the Aeromedical Services Information

Management System (ASIMS) using available unit, training status, student, and PASCODE rosters.

e) **Applicability to AU and Other Non-Technical Training Organizations.** Organizations whose primary mission is professional military education, doctrine, graduate education, or other non-technical instruction will not be included solely because they conduct resident education. However, the responsible Training Wing or Group commander may identify specific student, staff, or congregate-living populations when local conditions meet the criteria in paragraphs 1(a) and 1(b).

2. Rapid Deployment Forces and "No-Fail" Missions

a) **Definition.** All military personnel who are assigned or attached to forces required to deploy, project power, or respond globally on short or no-notice timelines (e.g. categorized as Tier 1 or immediate response forces), and all military personnel performing mission-essential functions whose illness, incapacitation, or quarantine would degrade, delay, or cause failure of a no-fail mission — particularly personnel occupying Low-Density/High-Demand (LD/HD) skill positions for which limited backfill capacity exists.

b) **Settings/Conditions Creating Elevated Risk.** Standing alert and immediate-response postures requiring intact, ready crews; small-team operations with no organic redundancy; geographically separated or remote operating locations with limited medical infrastructure; and mission sets in which a single illness can render an entire crew, team, or capability non-mission-capable.

c) **Population — Inclusive but Non-Exhaustive Enumeration.** This population includes (but is not limited to): (1) personnel standing alert, (2) immediate-response, or on-call status (e.g., crisis-action/response, quick-reaction forces, combat-coded rapid deployment forces); (3) Emergency relocation and Continuity of Operations (COOP) missions; (4) Chemical, Biological, Radiological and Nuclear Enhanced Response Enterprise members; (5) assigned Special Operations Forces (SOF) operators and their direct mission-support personnel; (6) HD/LD populations that are highly specialized, mission-essential cohorts characterized by lengthy training pipelines, persistent operational tempos exceeding standard dwell-time ratios, and specialized certifications that represent single-point mission failure risks (e.g., special warfare, cyber operations, specialized aviation, and critical infrastructure/sustainment enablers); (7) personnel assigned to geographically separated units (GSUs) operating with constrained or no organic medical infrastructure; and (8) specialized Air National Guard personnel that provide immediate local and regional response during catastrophic domestic disasters and weapons of mass destruction incidents, including but not limited to: Chemical, Biological, Radiological, and Nuclear Response Enterprise (CRE) personnel; aerospace control alert personnel, including but not limited to aircrew egress systems, aircraft maintenance, pilots and

aircrew, command and control, battle management personnel, and security forces personnel.

d) **Identifying Authority and Tracking Mechanism.** Required personnel will be identified by the responsible MAJCOM/FLDCOM commander, in coordination with functional managers and the supporting MTF. Unit commanders will ensure accurate unit personnel management rosters (UPMR) or rosters are provided to the MTF GMU/RMU POC so they can be tracked in ASIMS and validated prior to the annual compliance window in accordance with DoDI 6205.02, *DoD Immunization Program* and DAFI 10-250, *Individual Medical Readiness*. Commanders are responsible for ensuring that personnel are untracked immediately after they no longer meet the applicable criteria. These lists and associated requirements must be reviewed and renewed at least annually. Note: ANG and RC unit commanders will contact their Guard Medical Unit (GMU) and Reserve Medical Unit (RMU), respectively.

3. Deployed Forces

a) **Definition.** All military and DAF civilian personnel (and contractors in accordance with the terms of the applicable contract) who are deployed, or who are tasked to deploy, in support of named operations, contingency operations, command-directed exercises, or response missions, and who will operate in austere, expeditionary, or confined environments where communicable disease transmission is heightened and where outbreaks would degrade combat effectiveness and overburden limited theater medical assets IAW Combatant Command (CCMD) theater entry requirements.

b) **Settings/Conditions Creating Elevated Risk**. Austere and bare-base operating locations; expeditionary congregate billeting (tents, containerized housing); shared field dining, hygiene, and latrine facilities; confined transit and staging environments; and theaters with constrained medical evacuation and treatment capacity.

c) **Population — Inclusive but Non-Exhaustive Enumeration.** This population includes (but is not limited to): (1) all forces deployed in support of real-world named or contingency operations; (2) forces deployed for humanitarian assistance and disaster-relief missions; (3) forces conducting official travel or deploying in support of command-directed exercises and major training events in expeditionary settings; (4) healthcare personnel identified as short-notice augmentees, immediate response force medical elements, or quick-reaction clinical assets with the potential to deploy rapidly to reinforce theater operations; and (5) personnel tasked to deploy within the pre-deployment medical-readiness processing window, including short-notice deployers expected to depart within 14 days of vaccination—before sufficient immune protection is likely to develop

d) **Identifying Authority and Tracking Mechanism.** Theater entry requirements are established under CCMD authority. All deploying forces as identified in paragraph 2(c)

and 3(c) must be loaded and tracked in ASIMS in IAW with DAFI 48-122, *Deployment Health*.

4. Healthcare Personnel (HCP)

a) **Definition.** All paid and unpaid persons working in healthcare settings who have the potential for exposure to patients or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP includes both persons who provide direct or indirect care to patients and those not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from other HCP and patients.

b) **Settings/Conditions Creating Elevated Risk.** MTFs; GMUs and RMUs; inpatient and outpatient clinics; dental clinics; pharmacies; laboratories; mortuary/autopsy areas; emergency medical service and patient transport environments; and operational clinical services outside fixed MTFs (e.g., squadron medical elements, True North+, POTFF, ART, etc.) where exposure to patients or infectious materials is reasonably anticipated.

c) **Population — Inclusive but Non-Exhaustive Enumeration**. HCP might include (but are not limited to): physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, support staff, contractual staff not employed by the healthcare facility, volunteers, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from other HCP and patients. This includes embedded and rotational operational medical personnel who provide clinical care or operational medical services outside fixed MTFs

d) **Identifying Authority and Tracking Mechanism.** In accordance with DODI 6205.02, DoW establishes policy and assigns responsibilities for the administration of immunizations and force health protection measures to protect service members, designated DoW civilians, and contracted personnel from vaccine-preventable diseases. HCP will be tracked in ASIMS as a mandatory component of the MTF Medical Employee Health Program if assigned to or otherwise work within the MTF or as a component of IMR IAW DAFI 10-250. Service members will automatically flag in ASIMS while assigned to a medical Air Force Specialty Code (AFSC). Operational medical personnel and HCP assigned to units outside of MTF control who do not hold a medical AFSC will be identified by MAJCOM/SGs and unit commanders and tracked in a locally managed ASIMS immunization groups.

5. Civilian Personnel Employed in Child Development and Youth Services Programs

a) **Definition.** All civilian personnel employed in DAF Child and Youth Programs who have direct or routine contact with children, and who — by virtue of sustained contact within a

congregate childcare setting — have an elevated potential for influenza transmission to and from children, families, and other program staff.

b) **Settings/Conditions Creating Elevated Risk.** Child Development Centers (CDCs); School-Age Care and Youth Programs; Family Child Care (FCC) homes operating under program oversight; and congregate childcare classrooms, activity rooms, and shared program spaces with sustained close contact among children and staff.

c) **Population — Inclusive but Non-Exhaustive Enumeration.** This population includes (but is not limited to): (1) CDC caregivers, lead teachers, and program assistants; (2) School-Age Care and Youth Program leaders and direct-contact staff; (3) FCC providers operating under installation program oversight; (4) program directors and administrative staff with routine in-facility presence; (5) and supporting personnel (e.g., dietary, custodial, and volunteer staff) with routine exposure within these settings. This definition applies to both Appropriated-Fund (APF) and Non-Appropriated-Fund (NAF) employees.

d) **Identifying Authority and Tracking Mechanism.** Required personnel will be identified by the responsible installation Force Support Squadron/program authority, in coordination with the servicing Civilian Personnel Section (CPS). Influenza vaccination is established as a condition of employment for designated positions in accordance with 5 CFR Part 339 and DAFI 34-144 . Local Public Health personnel must assess, audit, and validate immunization records during routine sanitation inspections of CDC, FCC, and Youth Center facilities

Exclusions and Clarifying Notes. Non-compliance will be addressed through the servicing CPC in coordination with Labor and Employee Relations — not through the Uniform Code of Military Justice (UCMJ), as described in the guidance memorandum under Vaccination Refusals. For CYP civilian personnel specifically, the Mission Support Group commander or Space Base Delta Mission Support director approves or disapproves medical and religious immunization exemptions IAW DAFI 34-144, paragraph 10.4.5.2). Actions involving bargaining-unit employees must comply with applicable collective bargaining agreement (CBA) obligations, including required union notification or negotiation. Civilian religious or medical accommodation requests will be processed through Civilian Personnel/Equal Employment Opportunity (EEO) channels in accordance with applicable law and regulation.

6. Air Mobility Command (AMC) — Aircrew, Enroute Care, and Executive Airlift Personnel

a) **Definition.** All AMC military personnel who are assigned or attached as aircrew supporting United States Transportation Command (USTRANSCOM) tasking, all enroute care personnel, and all executive airlift personnel, who operate within confined aircraft cabins and closed environmental control systems for extended mission durations, and who may be tasked to deploy in support of the USTRANSCOM global mobility mission.

b) **Settings/Conditions Creating Elevated Risk.** Confined aircraft cabins with recirculated air; sustained crew-and-passenger proximity sorties; rapid global transit through multiple disease-exposure environments; close-quarters enroute patient care; and no-fail missions—including National Command Authority (NCA) and distinguished-visitor transport—in which crew illness directly threatens mission accomplishment.

c) **Population: all aircrew supporting USTRANSCOM, enroute care, and executive airlift, including but not limited to the following populations:**
   - USTRANSCOM aircrew: AMC pilots, navigators, and enlisted aircrew (e.g., loadmasters, flight engineers, boom operators) assigned or attached to support USTRANSCOM taskings.
   - Personnel supporting enroute care: patient-staging personnel, ground-support personnel who directly facilitate aeromedical evacuations (AE) operations, including AE liaison teams, and any other staff assigned to provide enroute patient care. Note: Requirements for medical/healthcare personnel are covered in Paragraph 4.
   - Executive airlift personnel: aircrew and mission-essential flight personnel assigned to designated executive/distinguished-visitor airlift units, including the Presidential Airlift Group/Squadron and designated airlift squadrons identified on the authoritative AMC unit list.

d) **Identifying Authority and Tracking Mechanism.** Unit commanders must manually compile and maintain a roster of all personnel postured for USTRANSCOM deployment taskings (including supporting ANG and AFR units). Because standard AFSCs and Unit Identification Codes do not cleanly isolate these individuals — particularly those in non-medical roles — commanders are responsible for ensuring rosters remain current and are provided to the MTF/GMU/RMU for loading into ASIMS. These lists and associated requirements must be reviewed and renewed at least annually.

Department of the Air Force (DAF) Influenza Vaccine Policy Exception

Frequently Asked Questions

WHO IS REQUIRED

Q) Who is required to receive the mandatory influenza vaccine under this exception?

A) While the influenza vaccination is voluntary for the broader military and civilian populations, the annual vaccination remains a readiness requirement for Airmen and Guardians, as well as designated civilian personnel, within the following six specific categories:

- Recruits, training populations, and congregate living (e.g., BMT, USAFA, OTS).
- Rapid deployment forces and "no-fail" missions (e.g., alert forces, AFSOC, designated alert assets).
- Deployed and deploying forces.
- Healthcare personnel (military, civilian, and contractor).
- Civilian and contract personnel employed in Child Development Centers (CDC) and Youth Services programs.
- Air Mobility Command (AMC) military personnel assigned as aircrew supporting USTRANSCOM taskings, enroute care personnel, and executive airlift personnel.

Q) I am in the Air Force Reserve or Air National Guard. Does this apply to me?

A) Yes, if you fall under any of the six ETP populations. You may be vaccinated during a scheduled duty period or by a civilian provider. Submit civilian vaccination documentation by your next Unit Training Assembly. You will not be placed in a paid duty status solely to receive the vaccine outside a scheduled duty period.

Q) I am a civilian or contractor who works in a military treatment facility. Does this apply to me?

A) It can. The Defense Health Networks (DHNs) determine which personnel working in Defense Health Agency military treatment facilities, outpatient clinics, and dental facilities are subject to mandatory annual influenza vaccination based on their status as a HCP or other personnel having direct contact or exposure to patients (DHA-Policy Memorandum 26-038). Ask your supervisor whether your position is covered.

Q) I am not in any of the required ETP population. Can I still get the vaccine?

A) Yes. The vaccine remains available to all other DAF personnel on a voluntary basis.

WHAT I NEED TO DO

Q) Are influenza vaccines covered by TRICARE, and where can I get them?

A) TRICARE covers the influenza vaccine at no cost when administered by a TRICARE-authorized provider, military hospital or clinic, or participating pharmacy. More information can be found at https://www.tricare.mil/fluvaccine. All personnel who receive the influenza vaccine from an authorized retail network pharmacy must provide documentation of vaccination no later than the next duty day, or the next Unit Training Assembly for Reserve and Guard members, to ensure compliance is appropriately recorded in ASIMS (date vaccine was administered, vaccine

name or code, manufacturer, expiration date, and lot number). Intranasal vaccine (FluMist) that is self-administered from a retail pharmacy will not be accepted for readiness requirement.

Q) If I was vaccinated with the Southern Hemisphere influenza vaccine, do I still need a Northern Hemisphere vaccine this fall?

A) Yes. The Southern Hemisphere vaccine does not meet the annual seasonal influenza requirement. The vaccine available this fall is specifically designed for our upcoming flu season and targets the specific strains projected to be circulating in the Northern Hemisphere.

Q) What if I miss getting vaccinated before flu season starts? Is it too late?

A) No, it is never too late to get vaccinated. While it is ideal to get your shot before flu season begins, getting vaccinated later in the season still offers crucial protection because flu activity most often peaks between December and February. Keep in mind that it takes about two weeks after your shot for your body to develop full immunity, so the sooner you get vaccinated during flu season (Oct – Apr), the better.

Q) Can I still get the flu even if I've been vaccinated?

A) It is still possible to catch the flu after being vaccinated, which often happens if you are exposed to the virus within the two-week window it takes to build up your immunity or if you encounter a strain not covered by the seasonal vaccine. Additionally, individual factors like age and underlying health conditions can affect how much immunity your body develops from the vaccine.

ASIMS, EXEMPTIONS, AND REFUSALS

Q) How will the Aeromedical Services Information Management System (ASIMS) be updated to reflect the new policy? (exempting and un-exempting)

A) Certain ETP populations were automatically identified and flagged within ASIMS (e.g., by training roster, by PAS code or AFSC, or when added to a deployment tasking), but certain highly mobile or mission-specific ETP populations could not be automatically identified by the existing system data fields. Individuals can be flagged in ASIMS through a locally managed immunization group feature that requires coordination with unit commanders and Immunization clinic, as outlined in the "Mandatory Influenza Vaccine Opt-Out Process."

Q) How do I request a medical exemption or a religious accommodation if I belong to a required population?

A) Service members may request a medical exemption or a religious accommodation. For a medical exemption, see your health care provider, who determines whether one applies under AFI 48-110_IP. For a religious accommodation, submit a request through your chain of command under DAFI 52-201. You are considered in compliance while a properly submitted request is pending, and no administrative or disciplinary action for refusal is started during that time. If your request is disapproved, you will have an opportunity to be vaccinated. Civilian employees submit religious exemption requests to their supervisor. For Child and Youth Programs personnel specifically, the Mission Support Group Commander or Space Base Delta Mission Support Director decides medical and religious immunization exemptions under DAFI 34-144.

Q) I am no longer in a required population. Does the requirement continue?

A) It ends when you no longer meet the definition. For deployers, the requirement ends at the deployment end date entered in ASIMS. For members in a locally managed immunization group, your commander notifies the Immunization clinic when you no longer meet the definition and the Immunization clinic removes you from the group, as outlined in the "Mandatory Influenza Vaccine Opt-Out Process." Commanders also update PAS codes and rosters when units or personnel leave a population.

BACKGROUND

Q) What is the general Department of War policy on influenza vaccines?

A) As of April 20, 2026, the Secretary of War established that the annual influenza vaccine is voluntary for all Active and Reserve Component Service members and Department of War civilian personnel.

Q) Why did the Department of the Air Force (DAF) request an exception to this policy?

A) The DAF requested an exception to the voluntary policy to protect mission-critical and high-risk populations. The mandatory vaccination for these select groups are deemed essential to preserve force readiness, prevent illness, minimize lost duty days, and ensure the successful execution of DAF missions.

Q) Who approved this Exception to Policy?

A) The Under Secretary of War for Personnel and Readiness granted the DAF's Exception to Policy request on June 11, 2026.

Q) What is the justification for making the vaccine mandatory for these groups?

A) The decision is based on a comprehensive risk-to-mission and risk-to-force assessment. These populations face higher risks of communicable disease transmission due to operating in dense environments (e.g., training facilities, aircraft cabins), austere locations, and healthcare settings. An influenza outbreak among these groups could have negative effects on force generation, compromise global power projection, and disrupt the operational availability of Airmen and Guardians.