AFFILIATED PHYSICIANS
ON-SITE VACCINATION AND WELLNESS SERVICES

Sign-In Sheet #

Influenza Vaccine Consent and Release

Demographic Information (All fields Required)

Agency/Location Name

Last Name | **First Name** | **M.I.**

Street Number and Address (Home)

City | **State** | **Zip Code**

Date of Birth (MM/DD/YYYY) | **Age**

Gender Identity

☐ Male ☐ Female ☐ Non-Binary

☐ Other

Phone Number ☐ Home ☐ Mobile

Medical Information

Influenza (Flu) is a very contagious respiratory virus that causes epidemic outbreaks of varying severity almost every winter. The influenza virus can mutate from year to year and protection from a dose of flu vaccine lasts about one year, so last year's vaccine will not protect you this year. Since the vaccine is made from inactivated virus, you cannot get the flu from receiving the vaccine. For the vast majority, the influenza vaccine will cause no side effects. The most common adverse reactions are soreness at the injection site, low-grade fever, or muscle aches for 24 to 48 hours after the vaccine is given. The vaccine you will receive contains trace amounts of Thimerosal. Women who are, or may be, pregnant, may wish to ask their physicians about vaccines containing Thimerosal before receiving the flu shot.

- You will not be eligible for the flu vaccination at this event if you are exhibiting COVID-19 symptoms as outlined by the CDC guidelines, such as, but not limited to: fever/chills, cough, shortness of breath, nausea or vomiting, etc.
- If you are allergic to eggs (or egg products), have a history of Guillain-Barre Syndrome, or have had allergic reaction(s) to prior influenza vaccines, you are not eligible for vaccination at this program. Please consult with your primary care provider.

Please check Yes or No for each of the following questions:

1. Are you allergic to eggs? ☐ Yes ☐ No
2. Do you have a history of Guillain-Barré syndrome (GBS)? ☐ Yes ☐ No
3. Do you currently feel sick? ☐ Yes ☐ No
4. Have you ever had a severe/life-threatening allergy to any component (or part) of the flu vaccine? ☐ Yes ☐ No
5. Is there a chance you are pregnant? ☐ Yes ☐ No ☐ N/A

HIPAA Privacy Notice: Affiliated Physicians, in accordance with HIPAA, can only disclose patient medical information for the reasons of treatment, inter-office operation and to receive payment for services. However, I understand that Affiliated Physicians may provide a record of this vaccination to my employer. As a patient, you have the right to inspect and retain copies of all medical records. You have the right to request in writing an amendment of your records, and any decision and action taken as a result of your request. You also have the right to restrict the disclosure of medical information released and to whom it is released. We will record and provide to you upon request, information about any release of your information other than the use of your information for the purposes listed above. You have the right to receive a paper copy of these guidelines in full and may receive that copy at the time of your visit, on our website at www.affiliatedphysicians.com, or by written request to the attention of the Compliance Officer. I understand I may request a copy of Affiliated Physicians' Notice of Privacy Practice at any time and it shall be provided to me upon such request.

Informed Consent: I have read the above information and have had a chance to ask questions about flu vaccine and HIPAA compliance. I understand the benefits and risks of the influenza vaccine and request the vaccine be given to me. I understand that my participation in my employer-sponsored Flu Vaccination program is voluntary. I understand that this vaccine may contain Thimerosal. I further agree to hold harmless Affiliated Physicians and my employer as well as either party's subsidiaries, officers, employees, agents, representatives, contractors, successors, and assignees any claim, or action arising out of or, in any way incidental to this vaccination. I understand that Affiliated Physicians may process a claim for this service with my insurance carrier. I authorize the release of any information needed to process this claim, and payment of these services to be released to Affiliated Physicians.

Patient Signature: **Date:**

Consent for Participation in Citywide Immunization Registry (CIR): The New York Citywide Immunization Registry (CIR) is a confidential, computerized system that allows authorized users access to a person's immunization records. Strict federal and state laws protect the privacy of personal information in the system. Participation in the CIR is voluntary for people 19 and older. I hereby grant permission to the NYC DOHMH to keep a record of my immunizations in the NYC Citywide Immunization Registry (CIR).

Patient Signature: **Date:**

Vaccine Information (Clinician Use Only)

Note for RNs: If administering a shot from a multi-dose vial, use the stickers provided to populate the vaccine information below and to the left. If you are administering a shot from a single dose syringe, use the vaccine information sticker from the barrel of the syringe and place it to the right below. Complete the remaining documentation by including your name, signature, date, injection site, dose, and VIS provided to the participant.

MFR: _____
Brand: _____
Lot: _____
Exp: _____

Influenza Vaccine Dose: ☐ 0.5mL

Injection Site (IM): ☐ R Deltoid ☐ L Deltoid ☐ Other _____

VIS Provided: ☐ v08.06.21

Thimerosal Free/Senior Vaccine (65+)
Place label from barrel here

RN NAME: **RN SIGNATURE:** **DATE:**