

Influenza Vaccine Consent and Release

Demographic Information **All Fields Required

Site Location

Last Name

First Name

Middle Initial

Street Number and Address

City

Date of Birth MM/DD/YYYY

Age

Gender Identity

☐ Male ☐ Female ☐ Other

Phone ☐ Mobile ☐ Home

State Zip

Medical Information

Influenza (Flu) is a very contagious respiratory virus which causes epidemic outbreaks of varying severity almost every winter. The influenza virus has the capacity to 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 prior to 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:

- Are you allergic to eggs? ☐ Yes ☐ No
- Do you have a history of Guillain-Barre? ☐ Yes ☐ No
- Have you ever had a severe reaction to influenza vaccine? ☐ Yes ☐ No
- Do you currently feel sick? ☐ Yes ☐ No
- Are you allergic to Thimerosal? ☐ Yes ☐ No
- Is there a chance you are pregnant? ☐ Yes ☐ No

7. Are you experiencing any of the following symptoms:

- | | | | |
|------------------------|--|------------------------------|--|
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sore Throat | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loss of taste or smell | <input type="checkbox"/> Yes <input type="checkbox"/> No | Runny Nose or Congestion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea, vomiting or diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chills | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Muscle aches | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Headache | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Persistent cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

HIPAA Privacy Notice: Affiliated Physicians, in accordance with HIPAA, can only disclose patient medical information for the reasons of treatment, inter-office operation and/or to receive payment for services. 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 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 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: As the patient or the patient's surrogate or guardian, 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 or community-sponsored Flu Vaccination program is voluntary. I understand that this vaccine may contain Thimerosal. I further agree to hold harmless Affiliated Physicians, business associates, 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 release of any information needed to process this claim, and payment of these services to be released to Affiliated Physicians.

➡ Patient/Surrogate/Guardian 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/Surrogate/Guardian 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 info box below and to the left. If you are administering Thimerosal-free vaccine, or high dose to 65 year old or older, use the vaccine information sticker from the barrel of the syringe and place in the second box below. Complete the remaining documentation by including - your name, signature, date, injection site, dose and VIS provided to participant

MFR: Brand: Lot: Exp:	Thimerosal Free/High dose (65+): Place label from barrel here	Influenza Vaccine Dose: <input type="checkbox"/> 0.5mL	Injection Site (IM): <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Deltoid <input type="checkbox"/> Other _____	<input type="checkbox"/> VIS Provided v08.06.21
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Clinician NAME:

Clinician SIGNATURE:

DATE:

TIME: