INFLUENZA VACCINE CONSENT AND RELEASE
City of New York

Participant# _____
(from sign-in sheet)

Demographic Information - *Please fill in the following information. Address and phone number should be for your home.*

Agency/Location Name

Employee ID # (if applicable)

Last Name

First Name

M.I.

Date of Birth M M / D D / Y Y Y Y

Age

Gender Male Female

Street Number & Address (Home)

Phone Number (Home or Cell) - -

City

State

Zip Code

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 being administered is made from killed or inactivated viruses, you cannot get the flu from receiving the vaccine.

Most people who receive the flu shot do not experience serious problems from it. Mild reactions that may be experienced include soreness, redness, or swelling where the shot was given, fainting (mainly adolescents), headache, muscle ache, fever, and nausea. If these problems occur, they usually begin soon after the shot was given and lasts 1 to 2 days. Serious allergic reactions to vaccines are very rare.

The vaccine you will receive contains trace amounts of thimerosal. You may wish to ask your physician about vaccines containing thimerosal prior to receiving the flu shot. There is also a non-thimerosal-containing (preservative-free) vaccine available for pregnant women.

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

1. Are you allergic to eggs?	☐ No ☐ Yes	4. Do you currently feel sick?	☐ No ☐ Yes
2. Are you allergic to thimerosal?	☐ No ☐ Yes	5. Do you have a history of Guillain-Barre?	☐ No ☐ Yes
3. Have you ever had a severe reaction to influenza vaccine?	☐ No ☐ Yes	6. Is there a chance you are pregnant?	☐ No ☐ Yes

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 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.

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 release of any information needed to process this claim, and payment of these services to be released to Affiliated Physicians.

X _____ **Date** _____
Patient Signature

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).

X _____ **Date** _____
Patient Signature

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 on the left. If you are administering thimerosal-free vaccine, use the Lot Info Sticker from the barrel of the syringe and place it in the second box. Then, complete the other boxes, including—your name and signature, the date, the injection site and that you made the VIS available.*

MFR Brand: Lot: Exp:	**Thimerosal Free: place label from barrel here**	**Injection Site (IM):** [ ] R Deltoid 0.5 mL [ ] L Deltoid 0.5 mL	**VIS provided on date of nurse signature below**	**VIS Published 8/07/2015**

RN NAME: _____ RN Signature: _____ Date: _____ NYC v2017