

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

Agency/Location Name											
Last Name						First Name				M.I.	
M M / D D / Y Y Y Y						Age		Gender (circle one)			
Date of Birth								Male		Female	Other
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 side effects from it. Mild reactions that may be experienced include soreness, redness, or swelling where the shot was given, fainting (mainly adolescents), headache, muscle aches, 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 Flu vaccine are very rare.

The vaccine you will receive contains trace amounts of Thimerosal. Thimerosal is a vaccine preservative made with ethyl mercury. Ethyl mercury is not the same as the type of mercury associated with fish (which is called Methylmercury). Ethyl mercury is quickly excreted from the body and does not cause harm. You may wish to ask your physician about vaccines containing Thimerosal prior to receiving the flu shot. There is also a Thimerosal-Free [T-Free] vaccine available for pregnant women.

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

- | | |
|---|--|
| 1. Do you have a severe allergy to eggs? <input type="checkbox"/> No <input type="checkbox"/> Yes | 4. Do you currently feel sick? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Do you have an allergy to any component of the Flu vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes | 5. Do you have a history of Guillain-Barre (GBS)? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Have you ever had a severe reaction to a Flu vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes | 6. Is there a chance you are pregnant? <input type="checkbox"/> No <input type="checkbox"/> 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 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: place label from barrel here	Injection Site (IM): <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Deltoid <input type="checkbox"/> Other _____	Date VIS Provided On date of nurse signature below	VIS Published v08.06.21
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