

# Influenza Immunization Consent Form

Name (please print)	Date of Birth	Date of Immunization November 3, 2009
Address	City	State Zip
Clinic/Office Site Where Vaccine is Administered (please circle) Brewster High School or Haldane School	Sex Male Female	Phone
Doctor's Name and Address		

- |   |                             |                              |                     |
|---|-----------------------------|------------------------------|---------------------|
| Is this your (your child's) first time getting the flu shot?                      | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Have you ever had a serious reaction to a flu shot?                               | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Are you pregnant?   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Are you a healthcare worker?  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Are you allergic to latex or rubber?  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Are you allergic to eggs?   | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Have you ever had Guillain Barre syndrome?  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Are you sick with fever?  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Are you allergic to Thimerosal or Gelatin?  | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Are you currently receiving radiation, chemotherapy or immunosuppressive therapy? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Do you have close contact with anyone with a weakened immune system?              | <input type="checkbox"/> NO | <input type="checkbox"/> YES |                     |
| Do you have a chronic medical condition?  | <input type="checkbox"/> NO | <input type="checkbox"/> YES | If Yes, What? _____ |

**RE: LAIV** \_\_\_\_\_

- |                                    |                             |                              |   |                             |                              |
|------------------------------------|-----------------------------|------------------------------|---|-----------------------------|------------------------------|
| Are you allergy to Gentamicin?     | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Are you a severe asthmatic?             | <input type="checkbox"/> NO | <input type="checkbox"/> YES |
| Are you receiving aspirin therapy? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | Do you presently have an active wheeze? | <input type="checkbox"/> NO | <input type="checkbox"/> YES |

**INFLUENZA CONSENT** I have read, or had explained to me, the information sheet about influenza vaccination. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

Signature of recipient (parent or guardian) \_\_\_\_\_ Date \_\_\_\_\_

Area Below to be Completed by Nurse

**Influenza Vaccine:** Administration Site:  Left arm  Right arm  Nasal      **Dosage :**  0.5 ml  0.25 m  LAIV

Manufacturer & Lot Number \_\_\_\_\_

I have reviewed side effects with patient (parent or guardian)

Next Immunization Due:  Next Year  in 4 weeks

Nurse Signature \_\_\_\_\_



# NYSIIS Consent Form

## CONSENT FOR PARTICIPATION IN NYSIIS FOR INDIVIDUALS 19 YEARS OF AGE OR OLDER

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-4437.

**I give my consent for Putnam County Department of Health to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.**

**The immunization information in NYSIIS may be released to the following: myself, my health maintenance organization, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.**

**I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided.**

**Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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