2016-2017 INACTIVATED INJECTABLE INFLUENZA CONSENT FORM

Information about person to be vaccinated (please print)

Last Name:_____ Age: _____

First Name: _____ Sex: ___M ___F

Date of Birth:_____ Phone # _____

Address _____

City _____ Zip _____

For child - Please Print

Parent's Name:_____

For child being vaccinated at school based clinic

Grade _____ School _____

for children: office use only

Child needs second dose _____

Assess if child needs second dose _____

Clinic :

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information in accordance with applicable HIPAA Privacy Act standards and requirements*. Immunization records remain confidential, and any person who fails to protect the information is guilty of a Class 1 misdemeanor. If you choose NOT to have you/your child's immunization record shared with other providers, you may request a refusal form.

INSURANCE COVERAGE

_____ Enrolled in Medicaid **MUST ATTACH COPY OF CARD**

_____ No health insurance

_____ Insurance **MUST ATTACH COPY OF CARD**

_____ American Indian or Alaskan Native

_____ Health insurance DOES NOT pay for vaccines **MUST ATTACH COPY OF CARD**

For Dependent: Name of policy holder _____ **Date of Birth** _____ **Relationship** _____

Please answer the following questions for the person to be vaccinated.	Yes	No
Are you sick today?	_____	_____
Do you have a serious allergy to medications, food, or latex?	_____	_____
Have you ever been diagnosed with Guillain-Barre Syndrome?	_____	_____
Have you ever had a flu shot?	_____	_____
Women: Are you pregnant or plan on becoming pregnant?	_____	_____

I have been provided a copy of and have read or have had explained to me the information about influenza and the vaccine listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

For insurance coverage indicated above, I give permission to Regional Health to submit a claim to my insurance for services provided and authorize payment of my insurance benefits directly to Regional Health.

Signature _____ Date _____

For child being vaccinated at a school based clinic

If you are completing this form for a child to be vaccinated at school and you will not be accompanying him/her, please provide a phone number where you can be reached on the day of the clinic _____ (Phone)

for office use only

	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Signature of person administering vaccine
INFLUENZA	IIV4		Sanofi Pasteur --- GlaxoSmithKline		IM	L R Deltoid Thigh	08/07/15	

Abbreviation Key: **IIV4** - Inactivated Influenza Vaccine, Quadravalent **IM** - Intramuscular **L** - Left **R** - Right

Regional Health
Massa Berry Regional Medical Clinic

Consent For Medical Care, Notice of Privacy Practices, Assignment of Benefits

1. **Consent for Medical Care.** The undersigned consents to the following:
   a. All initiation of care, consultation, treatment and procedures to be performed (including emergency treatment or services). The treatment and procedures may include, but are not limited to, laboratory test, x-ray examination, injections, medical or surgical treatment or procedures, anesthesia, or other services rendered under the general and special instructions of the patient's physician.
   b. Testing for HIV antibody (AIDS) and/or Hepatitis should the healthcare worker have an accidental exposure to patient's blood or other body fluids.
   c. The disposal of any body parts or tissues removed during the procedure according to clinic policy.
   d. Transfer and transportation to another facility for further care as instructed by the patient's physician.
   e. I consent to have allergies and code status listed on the front of my chart to insure my safety as a patient.
2. **General Risks.** The undersigned understands that the practice of medicine and surgery is not an exact science and diagnosis and treatment may involve risks ofinjury and even death. No guarantees can or have been made regarding the results of examination, procedures or treatment. I have the right to ask questions. I have the right to refuse treatment.
3. **Release of Billing Information.** The undersigned authorizes the clinic to release the following information:
   a. In order to determine liability treatment or services for payment or to obtain payment, the clinic may disclose all or portions of the patient's medical record to any person or entity or their agents who may be liable for all, or a portion of, the clinic's charges. The clinic's authority shall not be limited to release of the patient's diagnosis, surgical procedure, plan of care, and benefits by telephone at the time of treatment and the entities to whom the information may be released shall include but not be limited to insurance companies, health maintenance organization, worker's compensation carriers, government or other payers, or their agents such as utilization review, rehabilitation and auditing agencies. b. Clinical information to physicians and facilities for the purpose of continued health care. c. You expressly give your consent to receive artificial, pre-recorded or auto-dialed calls from Regional Health or its designated third parties to the designated cellular or residential telephone number(s) you provide for the purposes of telemarketing, debt collection or other purposes.
4. **Guarantee of Account.** The undersigned agrees, whether as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually obligates himself/herself to pay the account of the clinic in accordance with the Payment Policy of the clinic.
5. **Notice of Privacy Practices.** The law requires that we maintain the privacy of your Protected Health Information and we provide you with a notice of our legal duties and privacy policies with respect to protected health information. By signing below, I acknowledge I have received a copy of your Notice of Privacy Practices.
6. **Assignment of Insurance Benefits.** I assign directly to Regional Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, unless my employer has accepted responsibility for these services. I authorize Regional Health to release all information necessary to secure that payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

The following individuals are involved in my care and I give Regional Health staff permission to share my medical information with them.

Name:_____/Relationship:_____

Name:_____/Relationship:_____

Patient/Surrogate Decision Maker Signature	Date	Time
Patient/Surrogate Decision Maker Name PRINTED	Date	Time
Witness	Date	Time

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

Office Use Only

42 U.S.C. § 300aa-26