NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Influenza/Pneumococcal Immunization Consent Form

Name (Please Print)	Date of Birth	Sex	County of Residence
Address	City	State	ZIP
Phone	For Persons Under 19 Years Old, Mother's Maiden Name		
Medicare Claim Number	Doctor's Name		
Health Insurance Provider	Doctor's Address		
Policy Number	Clinic/Office Site Where Vaccine Administered		NYSIIS Permission ≥ 19 Years Old ☐ No ☐ Yes

Please complete the questions below for yourself or the person receiving the vaccine.

☐ No ☐ Yes Are you currently sick with a fever?

☐ No ☐ Yes Have you ever had a life threatening allergy to any component (or part) of the flu or pneumonia vaccine?
If yes, please describe: _____

☐ No ☐ Yes Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?

☐ No ☐ Yes Have you ever had a pneumonia shot?

☐ No ☐ Yes Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease?
If yes, please describe: _____

☐ No ☐ Yes Have you ever had a severe life threatening allergy to eggs or egg products?

☐ No ☐ Yes Are you currently pregnant?

☐ No ☐ Yes Do you have a history of asthma or wheezing?

☐ No ☐ Yes Are you a child or adolescent receiving long-term aspirin therapy?

☐ No ☐ Yes Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?

☐ No ☐ Yes Have you received any other vaccinations within the last 4 weeks?

☐ No ☐ Yes Have you taken an antiviral medication for the flu within the last 48 hours?

Influenza Consent

I have read, or had explained to me, the Vaccine Information Statement 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. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian) Date

Pneumococcal Consent

I have read, or had explained to me, the Vaccine Information Statement about **pneumococcal** 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 **pneumococcal** 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. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian) Date

Area Below to Be Completed by Nurse

Influenza Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm ☐ Nasal ☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV

Manufacturer & Lot Number _____

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ Next Year ☐ In 4 Weeks ☐ Other _____

Pneumococcal Disease Vaccine

Administration Date _____

Administration Site ☐ Left Arm ☐ Right Arm ☐ Left Thigh ☐ Right Thigh

Manufacturer & Lot Number _____

VIS Date _____

Nurse Signature _____

Next Immunization Due: ☐ None Needed ☐ Other _____

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 vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it 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 of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

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. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

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

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

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. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

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

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do 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. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- 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 **www.cdc.gov/flu**

OEHC
Occupational & Environmental
Health Center of Eastern New York

1873 Western Avenue • Albany, New York 12203
518/690-4420 • 800/419-1230 •Fax: 518/690-4427

Patients Record of Influenza Vaccination:

Name:_____

Date of Birth_____

Below to be completed by OEHC staff:

Influenza Vaccine:

Administration Date_____

Administration Site Left Arm Right Arm Nasal_____
Left Thigh Right Thigh

Dosage 0.5 ml 0.25 ml LAIV

Manufacturer & Lot Number_____

VIS Date_____

Nurse Signature_____

Next Immunization Due: Next Year