2013-14 INFLUENZA IMMUNIZATION FORM

THOMPSON HEALTH
350 Parrish Street
Canandaigua, NY 14424

Name (please print) Department Date of Birth Sex Phone #

Address City State Zip

Primary Work Site_____

Please Circle:
Associate / LIP / Volunteer or Student / Contract Personnel / Other

Complete this box if you have already received the 2013-14 Influenza Vaccine:

Name of Provider:_____ Date of Vaccine:_____

Address of Provider:_____

MUST PROVIDE A COPY OF THIS FLU VACCINE RECORD TO ASSOCIATE HEALTH

Continue to Signature and return to Associate Health along w/documentation

If you are receiving the 2013-14 Influenza Vaccine: Date of Immunization _____

Do you have health insurance? □ Yes □ No. If yes:
Insurance Name_____ Subscriber Name_____
Subscriber Number_____ Subscriber Date of Birth_____

□ Yes □ No Are you allergic to latex?
□ Yes □ No Do you have a chronic medical condition?
□ Yes □ No Have you ever had Guillian Barre syndrome?
□ Yes □ No Are you sick with fever?
□ Yes □ No Do you have a severe reaction to eggs or other vaccine components?

Influenza Consent: I have read, or had explained to me, the information sheet about the 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 consent to the administration of the Influenza vaccine by Thompson Health and request that the Influenza vaccination be give 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 an insurance claim or other public health purpose.

Signature of Recipient (parent or guardian) **Date**

Influenza Immunization: Injection Site:

□ Left Arm □ Right Arm Manufacturer & Lot #_____

□ I have reviewed side effects with patient: Nurse Signature_____

For Office Use:
HPN_____ Systoc_____
Ultipro_____ Billing_____

PER NEW YORK STATE, ANY ASSOCIATE/VOLUNTEER WHO HAS NOT BEEN VACCINATED WILL WEAR A MASK AT ALL TIMES WHEN AT THOMPSON, EXCEPT WHEN EATING.

Please Circle:

Associate / LIP / Student or Volunteer / Contract Personnel/ Other

IMMUNIZATIONS: INFLUENZA DECLINATION FORM

I understand:

- The **purpose** of and the need for the recommended vaccine(s) and the **risks and benefits** of the recommended vaccine(s).
- The Advisory Committee on Immunization Practices, the Centers for Disease Control and Prevention, and the New York Department of Health and Mental Hygiene all strongly recommend that the vaccine(s) be given.

If I do not receive the vaccine(s), the **consequences** may include increased risk of:

- Getting sick from the illness the vaccine could prevent.
- Spreading the disease to others who could become ill, be hospitalized, or die as a result.
- Being hospitalized for heart disease, stroke, pneumonia, or influenza, if I am 65 years of age or older.
- Death, if I am 65 years of age or older.

Nevertheless, I have decided to refuse the vaccine(s) recommended above. I know that my failure to follow these recommendations for vaccination may endanger my health or the health of people I come in contact with. I know that, even though I refuse to be vaccinated now, I can **change my mind at any time** and accept vaccination in the future. I acknowledge that I have read this refusal form in its entirety and fully understand it. I have had explained to me the risks and benefits of the vaccine(s). I have had a chance to ask questions about the benefits and the risks of the vaccine. All of my questions have been answered to my satisfaction. I do not wish to have the vaccine(s) administered to me, (or the person for whom I am authorized to make decisions) at this time.

Reason for Declination:

- ☐ I refuse the Influenza vaccine for medical reasons (contraindication to influenza vaccine- such as Guillan Barre Sydrome, a reaction within 6 weeks of the flu vaccine).
- ☐ I have a severe reaction to eggs or other vaccine components.
- ☐ I refuse the Influenza vaccine even though I am aware of the benefits and risks of the vaccine.
- ☐ I refuse the Influenza vaccine because it is against my religious beliefs.

Print Name _____ Primary Department _____

Resident/Participant/Associate Signature _____ Date _____

ANYONE WHO DECLINES VACCINE MUST COMPLETE A 1:1 WITH INFECTION PREVENTION OR ASSOCITE HEALTH, AND VIEW THE ASSIGNED VIDEO RELATED TO THE INFLUENZA

DATE(S) COMPLETED: _____ *WITH:* _____