PARKWAY DRUGS

Influenza 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 puropses. I have received a copy of the Patient Bill of Rights.

_____

Signature of Recipient (Parent or Guardian) Date

AREA BELOW TO BE COMPLETED BY PHARMACIST

Influenza Vaccine:

Administration Date:_____

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

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV

Manufacturer and Lot Number: _____
_____

VIS date_____

Pharmacist Signature_____

Next Immunization Due: ☐ Next Year ☐ In 4 Weeks ☐ Other_____

PARKWAY DRUGS

Customer Agreement - Authorization - Delivery Ticket

Name_____**HIC#/ID#**_____

Address_____

City_____**State**_____**Zip Code**_____

Phone Number_____**Date of Birth**_____

Sex_____**Marital Status**_____

Assignment of Insurance Benefits & Medical Information Authorization: I authorize direct payment to Parkway Drugs of any insurance benefits otherwise payable to me for Parkway Drugs provided products or services. I also authorize my insurance company(ies) to furnish to an agent of Parkway Drugs any and all information pertaining to my insurance benefits and status of claims submitted by Parkway Drugs for services rendered. I further authorize Parkway Drugs to release my insurance company(ies) (or HCFA and its agents) any and all information pertaining to me for benefit determination. I also hereby authorize any holder of medical information about me to release Parkway Drugs any records pertaining to my medical history, services rendered, or treatment. I consent to the release of my Parkway Drugs records to be reviewed by authorized representatives of Medicare/Medicaid, Medicare intermediary, and/or my private insurance company(ies) for use in determining my home health benefits. I further authorize accrediting or licensing bodies to periodically examine my records for the purpose of checking compliance to regulations and our quality assurance requirements.

Terms of Agreement and Medical Treatment Consent: I understand that by signing this agreement, I authorized provision of products or services to me by Parkway Drugs. I also understand that I am under the control of my attending physician and that Parkway Drugs is not liable for any act or omission when following the instructions of said physician.

Acknowledgment of Financial Responsibility: While there may be insurance coverage for those services or products provided by Parkway Drugs to me relative to my therapy needs, I recognize that all services may not be covered or that reimbursement may be less than 100% of charges billed, in accordance with my policy coverage. Therefore, I acknowledge financial responsibility for any balance owing on my account. I agree to transfer immediately to Parkway Drugs any payment made directly to me for services provided to Parkway Drugs on an assigned basis.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its items.

_____ _____

Beneficiary Signature Date

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

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) 473-2839.

I give my consent for Parkway Drugs **(name of doctor or organization) 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 insurance plan, 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 _____

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 and older, pregnant people, 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.

In an average 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 vaccines

CDC recommends everyone 6 months 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 the influenza viruses believed to be 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 vaccination 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 until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

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 the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- 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 members 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. 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.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- 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**.