Influenza Quadrivalent Vaccine Consent Form

Section 1: Information for Individuals receiving the 2019-20 Quadrivalent Influenza Vaccine (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** month________ day_______ year _________
ADDRESS			**Cell phone no.**___________________________
CITY	**STATE**	**ZIP**	☐ **Employee** ☐ **Student** ☐ **Spouse - SNC Employee Name:** ☐ **MCW Student**

Section 2: Vaccine Eligibility

A. Please mark YES or NO for each question.	**YES**	**NO**
1. Do you have a serious allergy to eggs?	☐	☐
2. Do you have an allergy to Thimerosol, medications, food, a vaccine component, or latex?	☐	☐
3. Do you have any other serious life-threatening allergies? Please list ___________________________________	☐	☐
4. Have you ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
5. Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving a vaccine?	☐	☐

B. Please mark Yes or NO for each question as applicable.	**YES**	**NO**
1. Have you received any vaccinations in the past 4 weeks? Vaccine: _______________________________ Date given: Month______Day_______Year___________	☐	☐
2. Are you sick today?	☐	☐
3. Do you have any of the following: asthma, metabolic disease (e.g. diabetes), no spleen, complement component deficiency, a cochlear implant, spinal fluid leak, disease of the lungs, heart, kidneys, liver, nerves(seizure, or brain condition), or blood? Please list: Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?	☐	☐
4.Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Explain if yes: Do you have a parent, brother, or sister with an immune system problem? Explain if yes:	☐	☐
5. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or have had radiation treatments?	☐	☐
6. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
7. Women only: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐

Section 3: Consent

CONSENT FOR VACCINATION:
I have been given a copy and have read, or have had explained to me, information about the disease and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me.
I give permission to share my immunization records with the Wisconsin Immunization Registry and my immunization Provider for the purpose of maintaining a complete and accurate record to assist in assuring full immunization. Check here ONLY if you do NOT give your permission. ☐

Signature ____ Date: month______ day ______year___________

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dosage	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2019-20 Flulaval Quadrivalent	/ /	☐ IM RD LD	0.5ml	ID Biomedical	Y5X93 Exp: June 2020	Registered Nurse

St. Norbert College Health Services

Acknowledgement of receipt of Privacy Notice
Health Insurance Portability and Accountability Act of 1996

By signing this form, I acknowledge that the St. Norbert College Health Services have made available to me its Privacy Notice, which explains how my health information will be handled in various situations. I may also go to the webpage to download a written copy of the HIPAA Policy at:
https://www.snc.edu/health/docs/hipaa/notice_of_privacy_practices2019.pdf
I have also been given a chance to discuss my concerns and questions about the privacy of my health information.

Privacy Policy Agreement Signature

HIPAA Privacy Policy:
By your signature, you acknowledge that your HIPAA privacy rights are available for your review in this office. You also acknowledge that upon your request (verbally or in writing), a copy/summary of your protected health information (PHI) can be disclosed to you personally in a secure electronic format or in hard copy. Any disclosure of your PHI to outside entities (not exempted from HIPAA), must be requested/authorized in writing.

Financial Responsibility Understanding

- ☐ I understand that Health Services is not an in-network provider for most insurance companies, but will attempt to bill the insurance company on file.
- ☐ I accept full responsibly for payment of balance after services have been rendered.
- ☐ For employee/spouse, balances will be posted on your account in the Bursar office.
- ☐ I have read, understand, and agree to the terms and conditions of this Health Services Financial Responsibility Agreement.

______________________________	______________________
First and Last Name (please print)	Date of Birth
______________________________	______________________
Signature	Date

Updated 10/2019