



**CENTER FOR CORPORATE WELLNESS  
SEASONAL FLU VACCINE PROGRAM  
2019-2020 CONSENT AND RELEASE FORM**

I have read the information contained in the CDC Influenza Vaccine Information Sheet (see attached) and understand the benefits and risks of the seasonal flu vaccine and request that the vaccine be given to me. I have been given the opportunity to ask questions and those questions were answered to my satisfaction.

<b>Patient Information</b>	Name (AS IT APPEARS ON YOUR INSURANCE CARD)		Email address	
	Street Address		City	State
	Home Phone ( ) ( )	Preferred <input type="checkbox"/>	Work Phone ( ) ( )	Preferred <input type="checkbox"/>
<b>Insurance Information</b>	Member ID #		Date of Birth (MM/DD/YY)	
	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Primary Insurance Co.	Group #

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: \_\_\_\_\_

Date: MM / DD / YY

CHECK YES OR NO TO THESE QUESTIONS. ASK NURSE ANY QUESTIONS PRIOR TO VACCINATION.	YES	NO
Have you ever had a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• If Yes, most recent year? _____</li> <li>• Did you ever have a serious reaction to an influenza vaccination?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a fever or other illness now?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or <u>think</u> you might be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on blood thinners (i.e. Coumadin, Heparin, Plavix, Warfarin)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had:		
o Guillain-Barre Syndrome? (a neurological disorder)	<input type="checkbox"/>	<input type="checkbox"/>
o Allergy/sensitivity to latex?	<input type="checkbox"/>	<input type="checkbox"/>
o Allergy/sensitivity to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
o Allergy to gentamicin?	<input type="checkbox"/>	<input type="checkbox"/>
o Allergy/sensitivity to thimerosal? (preservative contains trace amounts of mercury, used in some vaccines and contact lens solutions)	<input type="checkbox"/>	<input type="checkbox"/>

I hereby release NYU School of Medicine and any other organization(s) associated with this influenza vaccination program, their affiliates, directors, trustees, officers, employees, clinicians, physicians, successors and assign, from any and all liability arising from or in any way connected with this program. I agree to take responsibility for seeking medical care if I develop adverse or allergic reactions after receiving the seasonal influenza vaccination.

I acknowledge and consent that this consent/claim form may be duplicated and stored electronically, and that the electronic version will be considered as if it was the original.

**NYU LANGONE HEALTH NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

*By signing this form, I acknowledge that I have received a copy of NYU Langone's Notice of Privacy Practices (effective as of 08/01/2019).*

SIGNATURE: of Patient or Personal Representative

PRINT: Name of Patient or Personal Representative

**Proof of Vaccination letters provided upon request, only.**

*FOR CLINICIAN'S USE ONLY – Circle vaccine used, arm vaccinated and initial*

Vaccine Manufacturer: <b>GlaxoSmithKline</b>	<b>FLULAVAL</b> Regular Quadrivalent  <b>LOT# YA52P</b>	<b>FLUARIX</b> Preservative-Free Quadrivalent  <b>LOT# 25R27</b>	<u>CIRCLE THE ARM</u> <u>VACCINATED</u>  <b>L      R</b>	<u>INITIALS OF ADMINISTERING</u> <u>CLINICIAN</u>
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