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

YOU CANNOT RECEIVE A FLU VACCINE IF YOU DO NOT READ AND SIGN THIS FORM

PLEASE PRINT CLEARLY

FIRST NAME:______________________________ LAST NAME:________________________________

COMPANY NAME: ____

I have read the information contained in the CDC Influenza Vaccine Information Form (see attached). I believe that I 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.

	YES	NO
• Have you ever had a flu vaccine?	☐	☐
o If Yes, most recent year? __________________		
o Did you ever have a serious reaction to an influenza vaccination?	☐	☐
• Do you have a fever or other illness now?	☐	☐
• Are you pregnant or think you might be pregnant?	☐	☐
• Are you on blood thinners (i.e. Coumadin, Heparin, Plavix, Warfarin)?	☐	☐
• Have you ever had:		
o Guillain-Barre Syndrome? (a neurological disorder)	☐	☐
o Allergy/sensitivity to latex?	☐	☐
o Allergy/sensitivity to eggs?	☐	☐
o Allergy to gentamicin?	☐	☐
o Allergy/sensitivity to thimerosal? (a preservative containing trace amounts of mercury, used in some vaccines and contact lens solutions)	☐	☐

Proof of Vaccination letters are available upon request, only.

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 Health's Notice of Privacy Practices (effective as of 08/01/2019).

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Signature of Patient or Personal Representative **Print Name of Patient or Personal Representative**

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Date