Defeating the flu starts here

PATIENT CONSENT FORM – INFLUENZA (FLU) VACCINE

Initial:

_____ I voluntarily request physicians, nurses, technical assistants or other healthcare providers administer the flu vaccine, and I understand the benefits and risks of the vaccine.

_____ I understand that administration of the vaccine requires that I receive a shot (injection). I voluntarily consent to and authorize this procedure. I have received and read, or had read to me, the Vaccine Information Statement (VIS). I also understand that as with all medical treatments, there is no guarantee that I will become immune.

_____ I have been given the opportunity to ask questions about the vaccine, the risks of receiving or not receiving the vaccine, the procedure to be used, and the risks and hazards involved. I have had an opportunity to ask questions and they have been answered to my satisfaction. I have all the information I need to give this informed consent for myself or other person named below for whom I am authorized to sign.

_____ If I am injured by Concentra's administration of the vaccine, I understand that Concentra is not responsible for any loss, damage, or expense I may incur. I hereby release and discharge Concentra, together with all of its affiliates, subsidiaries, shareholders, officers, directors, employees, agents, and any other representatives from any and all liability, loss, damage, and expense that may arise out of or relate to the administration of the vaccine, except for Concentra's gross negligence.

Notice of Privacy Practices

Your name and signature below indicate that you have received a copy of Concentra's Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, you may contact Concentra's Privacy and Security Office at 800-819-5571, or PrivacyOffice@Concentra.com.

Completed by the Person to Receive the Vaccine

Name:	Date of Birth:	Age:
Address:	Home Phone:	
City	State:	Zip Code:
Company/Dept:	Emp ID:	
Signature	Date	
Witness	Date	

-- OFFICIAL USE ONLY --

MFG: _____ LOT#: _____ Exp. Date: _____ ☐ Afluria Trivalent ☐ Fluzone Trivalent ☐ Fluzone Quadrivalent

Inj. Site: _____ VIS Given: _____ VIS Edition Date: _____

Given By: (Print) _____ Title: _____ Signature _____ Date: _____

Final vaccine composition to be determined by the U. S. Food and Drug Administration (FDA). Concentra does not guarantee the effectiveness of the influenza vaccine.

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Defeating the flu starts here

Patient name: _____ Date of birth: ____ ____ ____
(month) (day) (year)

Screening Questionnaire for Inactivated Injectable Influenza Vaccination (Fluzone, Flulaval, Afluria, Fluarix, Fluvirin)

For adult patients as well as parent of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child an inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person being vaccinated have an allergy to eggs, thimerosal, neomycin, polymixin, gelatin, formaldehyde, formalin, beta-propiolactone, nonyl, or octyl phenol ethoxylate (Triton), sodium taurodeoxylcholate, sodium deoxycholate, polysorbate 80, gentamicin, ovalbumin hydrocortisone, octoxynol-10, α-tocopheryl hydrogen succinate sodium phosphate, calcium chloride, potassium chloride, potassium phosphate, sucrose or latex? *(There is NO latex in multi-dose flu vials.)*	☐	☐	☐
3. Has the person being vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person being vaccinated ever had Guillain-Barre' syndrome?	☐	☐	☐
5. **For California, New York, Missouri, Delaware and Washington ONLY** – Are you pregnant or younger than 3 years old? (younger than 8 years old for Delaware)	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Final vaccine composition to be determined by the U. S. Food and Drug Administration (FDA). Concentra does not guarantee the effectiveness of the influenza vaccine.

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Occupational Medicine – Authorization for Disclosure of Protected Health Information

HIPAA Release I hereby authorize Concentra to use and disclose protected health information from the record(s) of:

Patient's Name: _____ Birth date: _____

Complete → Address: _____

Copies of the following records shall be used and disclosed: medical records relevant to the purpose of services rendered on _____(date of service) and all other records related to that visit.

Confirmation of who may receive copies of your records I understand that copies of the records indicated above will be: **A.** Used by Concentra and its workforce; **B.** Used for treatment, payment, and health care operations; and C. Communicated to:

Name: N/A

Address: _____ City: _____ St: ____ Zip: _____

Fax Number: - - _____ Confirmation Telephone Number: - - _____

Alert regarding parties not required to protect your information I understand that to the extent any Recipient of this information, as identified above, is not a "Covered Entity" under Federal or State law, the information may no longer be protected by Federal or State privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient In other words, if you are asking Concentra to release this information to someone other than a healthcare entity and such related businesses, then that person does not have to keep your health information private under HIPAA laws.

Alert regarding employment-related treatment I understand that the use and disclosure of PHI in my medical record may be at the request of my employer if I am here for an employment-related event. This use and disclosure is conditioned on specific employer requirements for my initial and continued employment. It is limited to the minimum necessary information needed to accomplish the employer's intended purpose and any information permitted by other state and Federal regulations.

Alert regarding denial of treatment I understand that Concentra may not condition treatment on my completion of this authorization form except when the provision of health care is solely for the purpose of creating PHI for disclosure to a third party (example: random drug screen for my employer). **I understand if I am here for Workers' Compensation, under some state laws, I am not allowed to revoke authorization.**

Expiration of this authorization Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is: _____(one year from date of service).

Revoking your release authorization I understand that I may **revoke this authorization** in writing at any time except to the extent that Concentra has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice stating my intent to revoke this authorization to:

Name of Concentra Facility Lead: _____

Concentra Address: _____ Concentra Fax number: - - _____

Consent For Medical Treatment I give permission to Concentra Medical Center to perform the medical and surgical processes, treatment, and/or procedures that the physician and other non-physician providers and assistants may deem to be necessary. I agree that I am financially responsible to Concentra Medical Centers for charges resulting from my receipt of such medical and surgical processes, treatment, and/or procedures if such charges are determined non-compensable under the applicable state workers' compensation law.

X _____ ✍ Patient's Signature OR _____ ✍ Signature of Patient's Representative

X Date _____ Date _____

_____ Printed Name of Patient's Representative

_____ Explanation of your legal right to sign for Patient

I understand I am entitled to receive a copy of this authorization.

If you have HIPAA questions related to this form, please contact the Privacy Office at 1-800-819-5571.

Concentra® treated right

VACCINE INFORMATION STATEMENT

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 ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- 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. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does 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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- 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**

Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26

Office Use Only