BON SECOURS OCCUMED

Patient Information/Flu Vaccine Authorization

Company Name CITY OF NEWPORT NEWS	
Company Address 2400 WASHINGTON AVENUE, NEWPORT NEWS, VA 23607	
Company Phone 757-926-3929	**Company Contact** MICAH CHAVERS

Patient Information **(Please Print)**

Last Name		First Name	M.I.	Today's Date	
Home Address: Street		City	State	Zip Code	
ID# (ID Card or Drivers License)	Home Phone	Marital Status	Age	DOB	Sex
		☐ Married ☐ Divorced /Sep. ☐ Single ☐ Widowed			
List all Known ***Allergies***			Personal Physician (if any)		

Emergency Contact Information **(Person to contact in case of an emergency, spouse, parent etc.)**

Name	Last Name	M.I.	Relationship to Patient
Home Phone	Employer's Phone	Cell Phone	

AUTHORIZATION AND AGREEMENTS FOR MEDICAL TREATMENT

The undersigned hereby makes the following Acknowledgements regarding medical treatment to be provided to the patient whose name appears above

1. **Consent to Treatment** I, the undersigned, as the patient or on behalf of the patient, whose names appears above, do hereby consent to and authorize the administration of the influenza vaccine.
2. **No Guarantee of Results** I understand that no guarantee or assurance has been made to the results, which may be obtained
3. **As established in Virginia Law** (Virginia Code Section 32.1-45.1), I acknowledge that if a caregiver is exposed to my blood or body fluids in the course of my treatment, my blood will be tested for the Human Immunodeficiency Virus (HIV) antibody and the results released to the exposed caregiver. If I am exposed to the blood or body fluids of the caregiver in the course of treatment, the caregiver's blood will be tested for the HIV antibody and the results will be released to me.

I have read the above information, and fully understand the same. I acknowledge, by initialing that I have received the HIPAA notice of Privacy Practices in accordance with HIPAA Privacy Rule 164.502 ☐ Please Initial

Patient Name (print)	**Patient Signature**	**Witness Signature**	**Date**
Patient's Representative (Print)	**Representative's Signature**	**Witness Signature**	**Date**
Reason for Patient Not Signing:			
Telephone Permission received from:			
Witness:		Witness:	

Complete vaccine information and authorization for injection on reverse

BON SECOURS HAMPTON ROADS OCCUMED

2011-2012 INFLUENZA VACCINE CONSENT FORM ANDVACCINE REGISTRATION FORM

Target Groups For Vaccination

1. Persons over 50 years of age.
2. Residents of nursing homes and other extended-care facilities housing patients of any age with chronic medical conditions.
3. Adults who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medication).
4. Physicians, nurses and other personnel in hospital and outpatient care settings who may have contact with high-risk patients in all age groups including infants.
5. Household members of high-risk groups, whether or not they provide care.
6. Adults with chronic disorders of cardiovascular or pulmonary systems.
7. Any person who wishes to reduce the likelihood of influenza (who meets the eligibility criteria of this protocol)

Screening Criteria

- No one under the age of 18 will be given the vaccine under this protocol.
- Pregnant women must consult with their attending physicians and provide written approval before receiving the vaccine.
- Persons who are allergic to chicken eggs or to any other components of the vaccine, such as thimerosal (mercury derivative) will not receive this vaccine until they have consulted their attending physician and written medical approval is provided.
- Although gentamicin sulfate is not detectable by current assay procedures, the vaccine will not be administered to persons with a known sensitivity to gentamicin or other amino glycosides.
- Persons with acute febrile illness should not be vaccinated until their symptoms have subsided.
- Minor illness with or without a low grade fever, such as mild upper respiratory infections or rhinitis, should not contraindicate the use of the vaccine.
- Any person receiving anticoagulation therapy other than aspirin should consult with their physician and provide written medical approval.
- Any person who is immuno-suppressed should consult with their primary care physician and must and provide written medical approval to receive the vaccine.

Administration

The vaccine will be administered in the deltoid muscle, using universal precautions. The vaccine is stored at 35-46 degrees F. All syringes are disposed in a biohazard sharps container per regulated waste criteria. Additional supplies used that have come into contact with blood or other bodily fluids will be discarded in a biohazard container and disposed of accordingly by the administering facility. Any frozen vaccine will be discarded. Hand hygiene will be maintained using Alcare Foamed Antiseptic Hand rub. The above is in accordance with CDC,OSCH and JACHO regulations. The nurse will wear gloves to administer the vaccine and clean in injection site with antiseptic swab. If needed, a band-aid will be applied after the administration of the injection.

Post Immunization Follow-up

- Any reaction should be reported to your primary care physician and Bon Secours at 757-465-4000.
- All recipients will be requested to wait in the immediate area for 15 minutes to be monitored for any type of reaction.

Documentation/Retention of Patient Records

Records will be maintained by the administering facility. A copy is available upon request. This form is to serve as documentation.

Administering Personnel

- Persons administering the vaccine will be a registered nurse (RN) holding a current license in the state of Virginia or a licensed practical nurse (LPN) under the immediate and direct supervision of a RN.
- All providers are CPR certified and have an emergency kit with Epinephrine 1:1000.
- Medical Director (physician) provides standing order for the administration of vaccine.

Vaccine Description

This vaccine has been standardized according to USPHS requirements for the 2011-2012 influenza season and is formulated to contain 45 micrograms (mcg) hemagglutinin (HA) per 0.5ml dose, in the recommended ration of 15 mcg HA each, representative of the following prototype strains:

- A/California/7/09 (H1N1)-like virus (pandemic (H1N1) 2009 influenza virus)
- A/Perth /16/2009 (H3N2)-like virus
- B/Brisbane/60/2008-like virus

*Antigens change annually as determined by CDC

- Vaccine will begin to provide immunity after one to two weeks and immunity may decrease after several months.
- Flu shots are not effective against all possible strains of influenza virus.
- An injection of flu vaccine will not give you the flu, because the vaccine contains only noninfectious viruses.

I have read the above information and have had the opportunity to ask questions. I understand the benefits and risks involved. I request that the vaccine be given to me.

____________________ ____________________ ____________________ ________________

SSN Name (print) Signature Date

Circle one: Active employee Retired Employee Spouse

Allergies to eggs, chicken, and/or feathers? Yes No Last Menstrual Period: _______________

Virginia Information Sheet (CDC) given yes no publication date 07-26-11

Date of Vaccination: ________________ Site of Injection: Left Deltoid Right Deltoid Time Given: ___________

Vaccine Manufacturer & Lot Number/Exp Date: ____

Signature of Administrator of vaccine: ____ Reaction to vaccine? Yes No