OUHSC College of Pharmacy
1110 N. Stonewall Avenue, Oklahoma City, OK 73117
Influenza Immunization Program 2017 - 2018

Have you ever received an influenza (flu) vaccination?	YES	NO
Have you ever had a severe reaction to an influenza vaccine?	YES	NO
Are you allergic to eggs or chicken protein, neomycin, polymyxin, or gelatin?	YES	NO
Do you currently have a moderate to severe acute illness with or without fever?	YES	NO
Have you ever had Guillain-Barre Syndrome, a condition that causes paralysis?	YES	NO

I have read the information on the influenza vaccination and wish to receive an influenza vaccination. I consent to the vaccination being given to me by a pharmacist or College of Pharmacy student under the supervision of a pharmacist, a nurse or student nurse under the supervision of nurse, or other qualified healthcare professional. I have read the information for **Inactivated Influenza Vaccine 2017-18** and understand the risks and benefits of the Influenza Vaccine.

I hereby authorize OU College of Pharmacy to furnish to my insurance carrier(s) information concerning this vaccination and related documentation and assign to the College of Pharmacy all payments for the vaccination and services rendered to me.

Signature_____

I have had an opportunity to ask questions, all of which have been answered to my satisfaction, and I hereby waive any and all claims for damages arising out of or related to this vaccination that I (or anyone claiming on my behalf) may have against the Board of Regents of the University of Oklahoma, including, but not limited to, its Regents, employees, officers, directors, the OU College of Pharmacy, administering staff, pharmacists, student pharmacists, nurses, and student nurses. I understand that it is strongly recommended that I wait in the vaccination area for 15 minutes after administration of the vaccine for observation for possible related reactions.

I, _____, CONSENT TO RECEIVING AN INFLUENZA VACCINE INJECTION.
(**print** name of person receiving vaccination)

Signature _____ **Date** _____ **Date of Birth**_____
(**Patient** or Guardian)

I understand that the College of Pharmacy maintains a list of individuals receiving a flu vaccination**. If I am a student or an employee of the University of Oklahoma Health Sciences Center, I authorize the College of Pharmacy to release written confirmation that I received a flu shot, as well as the date of such service, to OU Physicians, HCA, the VA Medical Center, and other health care entities requiring confirmation of my flu immunization prior to permitting me to be a trainee or to provide services that require access to their patients or facilities.** I understand that:

- I may revoke this Authorization at any time, in writing, to the College of Pharmacy or University Privacy Official. My revocation will not apply to information already retained, used, or disclosed under this Authorization. Unless sooner revoked, the automatic expiration date will be sixty (60) months from the date of signature.
- The COP may not condition the provision of treatment or payment for my care on my signing this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- The information authorized for release may include information that may indicate the presence of a communicable or non-communicable disease.
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/ records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____
Date **Signature**

BELOW THIS LINE IS FOR CLINIC USE ONLY

Vaccine	Date Given	Manufacturer & Lot Number	VIS Edition Date	Site	Signature of individual administering vaccine
Fluzone			8/7/15		
Fluzone High Dose			8/7/15		
FluBlok			8/7/15		
Afluria			8/7/15		