MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE

LOCAL FORM TITLE *(Optional) Flu Vaccination Screen*

NHCA FLU CONSENT (Hospital Point)

Name (last, first):	Sponsor's Full SSN or Patient's DOD ID:	Status: (Please circle all that apply) MID/ Active Duty/ Dependent/ Retired/ CIV Healthcare/ Occupational Health CIV	
Date:	DOB:	Records Maintained at:	AGE:

Please Answer the Questions for the Person Being Immunized. This form should be completed by patient or legal guardian (if under age 18). By Completing the Form You Acknowledge the Following: Influenza Vaccine Information Sheet was available for review and that you understand the risks and benefits of the vaccine. You will wait in the clinic for 15 minutes to monitor for reaction (30 minutes for egg allergy patients).

1. Do you receive healthcare from the Johns Hopkins Family Health Plan? (If marked YES, please see TRICARE or health benefits manager before continuing)	NO	YES
2. At this time, do you have a fever or are you moderately to severely ill?	NO	YES
3. Have you ever had a serious reaction to a previous immunization?	NO	YES
4. Have you ever had Guillain-Barre Syndrome (a severe paralytic illness, also called GBS)?	NO	YES
5. Do you have any allergies to medications, foods (like eggs), vaccine components, or latex? Please list if YES _____	NO	YES
6. Are you taking aspirin or aspirin-containing therapy?	NO	YES
7. Are you currently pregnant or plan to become pregnant within the next 30 days?	NO	YES
8. Do you have heart disease, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder or any other chronic health conditions?	NO	YES
9. Do you have a history of wheezing, reactive airway disease, asthma, or lung disease?	NO	YES
10. Do you have a weakened immune system because of HIV or another disease that affects the immune system, long term high dose steroid treatments, or cancer treatment with radiation or drugs?	NO	YES
11. Have you taken any prescription medicines to prevent or treat influenza in the last 48 hours?	NO	YES
12. Are you in close contact with severely immunocompromised individuals who must be in a protective environment (such as transplant recipients)?	NO	YES
13. If the patient is under 9 years, has the patient received at least 2 TOTAL flu vaccines since 2010?	N/A NO	YES
14. Have you received any vaccines within the past month? Please list if YES _____	NO	YES

Medication Reconciliation *(Please list all the medications you are currently taking):* ☐ **Check if NONE**

Immunization Staff Use Only

Patient has no contraindications to the flu vaccine. The VIS was available in the clinic for review.	YES	NO
Patient's medications were reconciled prior to receiving the influenza vaccine.	YES	NO
Patient instructed to return to clinic in 1 month to receive 2nd dose if required.	YES	NO

FOR EGG ALLERGY PATIENTS ONLY
(Vaccine must be administered by RN or Provider).
Patient reports egg allergy but is able to consume or has mild symptoms such as hives. Patient denies systemic symptoms. Patient would like to get flu vaccine in clinic. Patient is instructed to wait 30 minutes in clinic after vaccination. Patient instructed that this is a BLS clinic and all reactions will need to be transported via ambulance to closest ER.
Patient/ Guardian Signature

Fluzone (injectable- pres. free)	Flulaval (injectable quad.)	Alfuria (injectable)	FLUMIST (intranasal)
6 – 36 mon	3 year and UP	9 year and UP	2 to 49 years
Dose 0.25 ml	Dose 0.5 ml	Dose 0.5 ml	Dose 0.2 ml (0.1ml in each nostril)
SITE- SEE AHLTA	SITE- SEE AHLTA	SITE- SEE AHLTA	R and L Nares

VACCINATOR'S NAME:	VACCINATOR'S SIGNATURE	DATE

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*

PLEASE SEE ABOVE FOR PATIENT IDENTIFICATION INFORMATION.

Office use if needed-

☐AHLTA ☐CHCS ☐Medical Record

HOSPITAL OR MEDICAL FACILITY	STATUS
NHC Annapolis and Branch Health Clinics	As noted above
DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
Immunizations	
SPONSOR'S NAME	SSN
n/a	As noted above
RELATIONSHIP TO SPONSOR	
n/a	

Category _____

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.

PRINCIPAL PURPOSE: To obtain supplemental medical data for use in immunization general consent.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to: treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delay of healthcare.