

**TALBOT COUNTY HEALTH DEPARTMENT  
ADULT FLU SHOT/ PNEUMOCOCCAL VACCINE CONSENT & ADMINISTRATION RECORD**

\*\*\*\*\* PLEASE PRINT INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE \*\*\*\*\*

NAME: Last		First	Middle Initial	Birth Date (mm/dd/yy)	AGE:	
ADDRESS: Number & Street (Apt #)			City	County	State	Zip
SEX: M / F	Daytime Phone #: ____ - ____ - _____					

\*\*\*\*\* PLEASE CIRCLE YES OR NO FOR EACH QUESTION. \*\*\*\*\*

<b>QUESTIONS 1-4 DETERMINE IF VACCINE CAN BE GIVEN:</b>		
1. Are you moderately or severely ill today WITH A FEVER?		YES NO
2. Have you ever had SEVERE/UNUSUAL REACTION after receiving any vaccine? Describe the reaction: _____		YES NO
3. Did the reaction involve PARALYSIS and/or occur within 6 wks after having flu vaccine?		YES NO
4. Have you ever had SEVERE ALLERGIC REACTION TO EGGS?		YES NO
<b>QUESTIONS 5-10 DETERMINE IF SPECIAL PRECAUTIONS NEED TO BE TAKEN:</b>		
5. Do you have diabetes or other metabolic disorder, or diseases of the lungs, heart, kidneys, liver, blood or nervous system? _____		YES NO
6. Do you have a weak immune system (from cancer, HIV or medicines containing steroids or for treating cancer)? _____		YES NO
7. Do you have any bleeding disorders or take aspirin or other anticoagulants every day?		YES NO
8. Are you pregnant at this time?		YES NO
9. List all your current medications. _____		
10. List all your allergies. _____		

\*\*\*\*\* PLEASE READ AND SIGN CONSENT ON THE LINE BELOW. \*\*\*\*\*

"I have read or had explained to me the information in the Vaccine Information Statement(s) (VIS) for influenza and/or pneumococcal vaccines. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that they be given to me or to the person named above for whom I am authorized to make this request."  
 "If not paying by cash today, I authorize the Talbot County Health Department to bill my insurance company (Medicare or Medical Assistance only) for services given to the person named above."  
 "I have been given or offered a copy of the Notice of Privacy Policies (HIPAA) form."  
 X \_\_\_\_\_ Relationship: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 (Signature of person receiving or consenting to the vaccination)

**FOR CLINIC USE ONLY BELOW THIS LINE**

Vaccine given:	INFLUENZA	Pneumococcal (PPSV23)
Date of VIS:	8/15/2019	04/24/2015
Route of Administration: (Circle one)	IM: LA RA LL RL	IM: LA RA LL RL
Vaccine Manufacturer:		
Vaccine Lot #/Expiration date:	Place label here.	Place label here
Signature & Title of Vaccine Administrator:		Today's Date:

# MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND YOUR HEALTH INFORMATION

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

### Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is committed to protecting your health information. DHMH is required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that we obtain from you or others that relate to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. In order to provide treatment or to pay for your healthcare, DHMH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information, may be used for a variety of purposes. DHMH and its Business Associates are required to follow the privacy practices described in this Notice, although DHMH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new Notice from any DHMH agency. It is also posted on our website at <http://dhmh.maryland.gov>.

### Permitted Uses & Disclosures

DHMH employees will only use your health information when doing their jobs. For uses beyond what DHMH normally does, DHMH must have your written authorization unless the law permits or requires it, and you may revoke such authorization with limited exceptions. The following are some examples of our possible uses and disclosures of your health information:

#### **Uses and Disclosures without Consent Relating to Treatment, Payment, or Health Care Operations:**

- **For treatment:** DHMH may use or share your health information to approve, deny treatment, and to determine if your medical treatment is appropriate. For example, DHMH health care providers may need to review your treatment with your healthcare provider for medical necessity or for coordination of care.
- **To obtain payment:** DHMH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.
- **For health care operations:** DHMH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

#### **Other Uses and Disclosures of Health Information Required or Permitted by Law:**

- **Information purposes:** Unless you provide us with alternative instructions, DHMH may send appointment reminders and other materials about the program to your home.
- **Required by law:** DHMH may disclose health information when a law requires us to do so.

- **Public health activities:** DHMH may disclose health information when DHMH is required to collect or report information about diseases, injuries, or to report vital statistics to other divisions in the department and other public health authorities.
- **Health oversight activities:** DHMH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.
- **Coroners, Medical Examiners, Funeral Directors and Organ Donations:** DHMH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.
- **Research purposes:** In certain circumstances, and under the supervision of our Institutional Review Board or other designated privacy board, DHMH may disclose health information to assist medical research.
- **Avert threat to the health or safety:** In order to avoid a serious threat to health or safety, DHMH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Abuse and neglect:** DHMH will disclose your health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, or some other crime. DHMH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **Specific government functions:** DHMH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- **Family, friends, or others involved in your care:** DHMH may share your health information with people as it is directly related to their involvement in your care or payment of your care. DHMH may also share your health information with people to notify them about your location, general condition, or death.
- **Worker's compensation:** DHMH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.
- **Patient directories:** DHMH entities generally do not maintain directories for disclosures to callers or visitors who ask for you by name. However, if a DHMH entity does maintain a directory, you will not be identified to an unknown caller or visitor without authorization, and the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.
- **Lawsuits, disputes and claims:** If you are involved in a lawsuit, a dispute, or a claim, DHMH may disclose your health information in response to a court or administrative order, subpoena, discovery request, the investigation of a complaint filed on your behalf, or other lawful process.
- **Law enforcement:** DHMH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.
- **Other parties for conducting permitted activities:** DHMH may conduct the above-described activities ourselves, or we may use non-DHMH entities (known as Business Associates) to perform those operations. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.
- **Fundraising Activities:** DHMH may use information about you to contact you in an effort to raise money for DHMH and its operations. The information we release about you will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at DHMH.

### **Your Rights**

#### **You Have a Right to:**

- **Request restrictions:** You have the right to request a restriction or limitation on the health information DHMH uses or discloses about you. DHMH will accommodate your request if

possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, DHMH must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

- **Request confidential communication:** You have the right to ask that DHMH send you information at an alternative address or by alternative means. DHMH must agree to your request as long as it is reasonably easy for us to do so.
- **Inspect and copy:** With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the protected health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. If DHMH maintains your health information using electronic health records, we will provide access in electronic format and transmit copies of the health information to an entity or person designated by you, provided that any such choice is clear, conspicuous, and specific.
- **Request amendment:** You may request in writing that DHMH correct or add to your health record. DHMH will respond to your request within 60 days, with up to a 30-day extension, if needed. DHMH may deny the request if DHMH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If DHMH approves the request for amendment, DHMH will change the health information and inform you, and DHMH will tell others that need to know about the change in the health information.
- **Require authorization:** You have the right to require your authorization for most uses and disclosures of psychotherapy notes, for receiving marketing communication and for the sale of your PHI.
- **Receive accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, and in the six years prior to the date on which the accounting is requested. Exceptions are health information that has been used for treatment, payment, and health care operations. In addition, DHMH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officers, or correctional facilities. There will be no charge for up to one such list each year. Additionally, DHMH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to three years prior to date of request.
- **Opt-Out:** You have the right to receive fundraising communication and the right to request to opt-out of fundraising communication. You also have a right to opt-out of a DHMH facility's patient directory.
- **Receive notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by mail upon request.
- **Receive breach notification:** You have the right to receive notification whenever a breach of your unsecured PHI occurs.
- **Receive protection of genetic information:** If any of DHMH's health care components is considered a health plan, the health plan is prohibited from using or disclosing your genetic information for certain underwriting purposes.
- **Receive protection of mental health records:** If a medical record that is developed in connection with you receiving mental health services is disclosed without your authorization, DHMH will only release the information in your record that is relevant to the purpose for which the disclosure is sought.

**For More information:**

This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact: **Donna Kegley-Hacker, Talbot County Health Department, 410-819-5629.**

**To Report a Problem about our Privacy Practices:**

If you believe that your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Department of Health and Mental Hygiene, Division of Corporate Compliance at 1-866-770-7175.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the Department of Health and Mental Hygiene for the contact information.

DHMH will take no retaliatory action against you if you make such complaints.

**Effective Date:** This notice is effective on August 19, 2013.

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**(Provider programs must ensure that they try to get this acknowledgement signed)**

Acknowledgement of receipt of this notice:

\_\_\_\_\_  
Patient or Authorized Representative

\_\_\_\_\_  
Date

If unable to get acknowledgement, specify why:

\_\_\_\_\_  
Signature of DHMH representative

# 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](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

## 1 Why get vaccinated?

Influenza vaccine can prevent influenza (flu).

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it 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 of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

## 2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

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. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

## 3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.



## 4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

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. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

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

## 5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do 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. Visit the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

## 7 How can I learn more?

- Ask your healthcare provider.
- 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 [www.cdc.gov/flu](http://www.cdc.gov/flu)

Vaccine Information Statement (Interim)  
**Inactivated Influenza  
Vaccine**



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