PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME _____

MRN _____ FIN _____

UNIVERSITY MEDICAL CENTER
LUBBOCK, TEXAS

Texas Department of State Health Services

Addendum to Live, Intranasal Influenza Vaccine
Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Vaccine to be given: ☐ Live, Intranasal Influenza Vaccine

***STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.**

Provider Identification Number: _____

Medicare Health Insurance Claim Number: _____

Information about person to receive vaccine (Please print)				
Name: Last / First / Middle Initial			Birthdate (mm/dd/yy)	Sex (circle one) M F
Address: Street	City	County	State: TX	Zip
Signature of person to receive vaccine or person authorized to make the request (parent or guardian): X _____ Date _____				
X _____ Witness _____ Date _____				

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Injection:
Signature of Vaccine Administrator:
Title of Vaccine Administrator:

PRIVACY NOTIFICATION - With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Instructions: File this consent statement in the patient's chart.