



9.1.2023

Influenza Vaccine Consent for Healthcare Workers 2023-2024

Print Name: Melinda Diaz (Circle One) Memorial East TM Sierra TRA
Date of Birth: 06/73 Last 4 of SS #: 768
Title: RN Department Name: ED
Email: md939@providence.com Phone Number: 915-203-2697

Do you work in an inpatient Rehab unit that is part of this facility? ☐ Yes ☒ No
Do you work in an inpatient Psychiatric Unit that is part of this facility? ☐ Yes ☒ No

Your position at the facility:

☐ Employee (staff on facility payroll) ☐ Physician / Allied Health ☐ Adult student / volunteer
☒ Contract personnel (EVS, Morrison, Conifer, Dialysis, etc.) ☐ Other TRA

Vaccination Screening Questionnaire:

Are you moderately or severely ill (with or without a fever)? ☐ Yes ☒ No
Have you ever had a severe allergic reaction to the flu vaccine? ☐ Yes ☒ No
Have you ever had Guillain-Barre Syndrome (GBS) less than 6 weeks after a previous dose of flu vaccine? ☐ Yes ☒ No
Are you allergic to egg products? ☐ Yes ☒ No
If yes: Have you ever had a severe reaction to eggs or egg products (i.e., swelling, trouble breathing)? ☐ Yes ☒ No
Are you allergic to any of the components in this vaccine? ☐ Yes ☒ No

If you answered yes to any of the above questions, speak with Occupational Health before getting the Influenza vaccine.

Influenza (flu) is a contagious respiratory illness that circulates throughout the United States each year, usually between October and May. Symptoms include fever, chills, sore throat, muscle aches, fatigue, cough, headache, runny or stuffy nose, vomiting, and diarrhea.

The vaccine may prevent influenza illness or lessen the severity of this illness. The vaccine may cause soreness, redness, and swelling where the shot is given, fever, muscle aches, and a headache. There is a small increased risk of Guillain-Barre Syndrome (GBS). If after vaccination you experience any complications that may be related to the influenza vaccine, contact your doctor and vaccine administrator for potential reporting.

CDC recommends the flu vaccine to everyone 6 months and older each flu season. It takes about 2 weeks after vaccination to develop immunity.

- I have read and understand this Influenza vaccine consent form.
- I have had the opportunity to discuss any concerns with my doctor.
- The administration of the vaccine does not create a patient-provider relationship between administrator and recipient.
- I understand the risks and benefits of the Influenza vaccine.
- I did not have a severe allergic reaction after a previous dose of any Influenza vaccine.
- I do not have a severe allergy to any part of this vaccine.
- I do not have a history of Guillain-Barre Syndrome (GBS) less than 6 weeks after a previous dose of flu vaccine.
- I am not moderately or severely ill.
- I freely and voluntarily request to receive the Influenza vaccine.

Signature: Melinda DiazDate: 9/21/23Manufacturer: ☒ Fluzone ☐ Fluarix ☐ Flucelvax ☐ High Dose Fluzone (over 65 years of age)Lot # UT8076KA Exp. Date 2024/06Route IM (circle one) Left deltoid Right deltoid Date Given 9/21/23Printed Name of Vaccine Administrator Rodolfo Acen

COVID-19 Vaccination Record Card



Please keep this record card, which includes medical information about the vaccines you have received.

Por favor, guarde esta tarjeta de registro, que incluye información médica sobre las vacunas que ha recibido.

Last Name Diaz First Name Claudia MI

Date of birth 12/2/73 Patient number (medical record or IIS record number)

Vaccine	Product Name/Manufacturer <small>Lot Number</small>	Date	Healthcare Professional or Clinic Site
1 st Dose COVID-19	COVID19 VACCINE Lot# EJ1685 Exp:03/2021 <small>Mfg: Pfizer</small>	12/19/20 <small>mm dd yy</small>	THOP EAST
2 nd Dose COVID-19	Pfizer - COVID19 Vaccine Lot# EL3249 Exp:05/21/2021 <small>Mfg: Pfizer</small>	1/7/21 <small>mm dd yy</small>	THOP East
Other		<small>mm dd yy</small>	
Other		<small>mm dd yy</small>	

Name (Nombre) Diaz Claudia Y
Last (Apellido) _____ First (Nombre) _____ Middle Initial (Inicial) _____
Date of Birth (Fecha de Nacimiento) 12-2-73 Sex (Sexo) F
Address (Dirección) 4308 Chester Avenue
City (Ciudad) El Paso State (Estado) TX Zip (Código Postal) 79902
Social Security Number (Número de Seguro Social) _____

Bring this record each time you come to the clinic. Keep this record. An immunization record is required to enroll in childcare, school, and most colleges, and for some jobs. This Immunization Schedule is recommended by the New York Department of State Health Services. Your doctor may recommend a different schedule.

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, 552.073, 559.003, and 559.004)

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

Traiga este registro cada vez que venga a la clínica. Guarde este registro. Se necesita para matricularse en una guardería infantil, la escuela, la mayoría de las universidades y para algunos empleos. Este calendario de vacunas es recomendado por el Departamento Estatal de Servicios de Salud de Texas. Su doctor puede recomendar otro calendario.

Notificación Sobre Privacidad - Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar que se elimine información sobre la información que el estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información si la requiere. Usted también tiene el derecho de poder que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a <http://www.dshs.state.tx.us> para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Aviso sobre derechos de la vida privada: Yo admito haber recibido una copia del Aviso Sobre Derechos de la Vida Privada (HIPAA).

Birth	1 Month	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	24 Months	4-6 Years	11-12 Years	15 Years	16-18 Years
Al Nazeer	1 Mox	2 Moxes	4 Moxes	6 Moxes	12 Moxes	15 Moxes	18 Moxes	24 Moxes	4-6 Alox	11-12 Alox	15 Alox	16-18 Alox
Hep B	Hep B	Hep B	Hep B				Hep B Series					
	DTaP	DTaP	DTaP	DTaP		DTaP						
	IPV	IPV	IPV	IPV		IPV						
				MMR		MMR						
				Varicella		Varicella						
				PCV		PCV						
				Influenza Yearly		Influenza Yearly						

Rede de Relacionamento Agências de notícias

☐ Caching Inmigraciones
inmigracione para la actualizacion

11-12 year old assessment
évaluation de fin 11-12 ans de l'état

DTaP - difteria, tétanos, y acelular pertussis
Hep A - hepatitis A
Hep B - hepatitis B
Hib - *Haemophilus influenzae* tipo b
Td - tétanos and difteria
MMR - measles, mumps, and rubella
Varicella - chickenpox
PCV - pneumococcal conjugate
PPV - pneumococcal polysaccharide

DTaP - difteria, tétanos y pertussis acelular
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Td - tétanos y difteria
MMR - sarampión, paperas y rubéola
Varicella - varicela o viruela lla
PCV - neumocócica conjugada
PPV - neumocócica polisacárida

Clinic Name (Nombre de la Clínica)

Clinic Phone Number (Teléfono de la Clínica)

Name (Nombre) Claudia Diaz Date of Birth (Fecha de Nacimiento) 12-02-12

Date (Fecha)	Vaccine (Vacuna)	Validation (Validación)	Next Dose (Próxima Dosis)
12-08-06	Hepatitis B #1	Tigua Health Center	for
1-1-07	Hepatitis B	TIGUA IMM. OUTREACH	for
4-10-07	Hepatitis B #3	Tigua Health Center	for
12-08-07	DTaP/DT/DTP/Td (Tdap)	Tigua Health Center	for
12-1-15	DTaP/DT/DTP/Td (Tdap)		
	DTaP/DT/DTP/Td (Tdap)		
	DTaP/DT/DTP/Td (Tdap)		
	DTaP/DT/DTP/Td (Tdap)		
	DTaP/DT/DTP/Td (Tdap)		
	Hib		
	Hib		
	Hib		
	Hib		
	Pneumococcal Conjugate		
	Pneumococcal Conjugate		
	Pneumococcal Conjugate		
	Pneumococcal Conjugate		
	IPV/OPV		
	IPV/OPV		
	IPV/OPV		
	IPV/OPV		
	Rotavirus		
	Rotavirus		
	Rotavirus		
12-08-06	MMR #1	Tigua Health Center	for
1-1-07	MMR	TIGUA IMM. OUTREACH	for
	Measles (Sarampión)		
	Varicella (Chickenpox)		
	Varicella (Chickenpox)		
	Varicella History / Date of Varicella Disease		
	MCV4		
	MPSV4		
	Hepatitis A		
	Hepatitis A		
	Pneumococcal Polysaccharide		
	Influenza		
	Influenza		

TB Test	Date Read	Results	TB Test	Date Read	Results
TB Test	Date Read	Results	TB Test	Date Read	Results
TB Test	Date Read	Results	TB Test	Date Read	Results

UCare

2051 North Zaragoza El Paso, TX 79938

915-703-8254

Patient Name:	DIAZ, CLAUDIA	DOB:	12/2/73
Patient MRN:	56315	Gender:	F
Study Date:	Oct 4, 2023 8:58:01 AM MDT	Accession:	OP-01607472373
Description:	CHEST	Ref Phys:	Miguel Anchoado PNP
Number of Views:	1		

HISTORY / PRELIM DIAGNOSIS: R/O TB

CHEST:

FINDINGS:

No definite segmental or lobar consolidation is seen.
Both CP angle appears intact.
Hila and mediastinum appear grossly unremarkable.
Cardiac size is within normal limits.
The rib cage appears grossly unremarkable.

IMPRESSION:

No definite consolidation or pleural effusion is seen.
No radiological evidence of tuberculosis.

Electronically signed on Oct 4, 2023 10:19:18 AM MDT (ET) by:
Amjad A. Sofvi, M.D.