HAYSMED

Patient Influenza Vaccine Consent

PAWNEE VALLEY COMMUNITY HOSPITAL
A HAYSMED PARTNER

You have come today to receive the Influenza vaccine from HaysMed or Pawnee Valley Community Hospital.

Please complete the following questions:

Do you have a severe allergy to eggs?	☐ Yes	☐ No
Do you have an allergy to latex?	☐ Yes	☐ No
Do you have a known sensitivity to thimerosal?	☐ Yes	☐ No
***Thimerosal, a mercury derivative used in contact lens solutions.**		
Have you had a known past history of Guillain−Barre' Syndrome?	☐ Yes	☐ No
Are you currently sick or running a fever?	☐ Yes	☐ No
Do you have a history of wheezing or asthma?	☐ Yes	☐ No

AUTHORIZATION TO RECEIVE INFLUENZA VACCINE AND FULL RELEASE FROM LIABILITY

I hereby consent to receive the influenza vaccine and authorize designated staff to administer the vaccine to me. I understand that additional doses of the vaccine may be required should new strains of the virus be discovered. Furthermore, I understand that there is no guarantee that complete immunity will result from this immunization and that its effects are only good for one year.

I have read, or had explained to me, the Vaccine Information Statement for the seasonal flu vaccine and understand the risks and benefits to receiving such vaccine. I hereby release HaysMed and Pawnee Valley Community Hospital, its employees, representatives, agents, volunteers, and medical staff from any and all claims and liability that may arise out of giving me this vaccine. I agree to indemnify, defend, and hold HaysMed and Pawnee Valley Community Hospital harmless from any and all expenses, losses, and claims made by me or others that arise out of or result from my receiving this vaccination.

I HAVE READ THIS RELEASE CAREFULLY BEFORE SIGNING IT AND HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT THIS PROCEDURE.

Signature of person receiving the vaccine (or guardian if a minor) _____ **Date/Time** _____

Print Legal Name of person receiving the vaccine _____ ☐ **Male** ☐ **Female** **Date of Birth** _____

Street Address _____ **City/State/Zip** _____

Print Your Physician's Name _____ ☐ I am a HaysMed Associate

FOR THOSE PATIENTS WHO SEE A PRIMARY CARE PROVIDER AT HAYSMED OR PAWNEE VALLEY COMMUNITY HOSPITAL − THIS VACCINE ADMINISTRATION WILL BE ENTERED INTO YOUR ELECTRONIC MEDICAL RECORD.

To be completed by **Nurse / Physician:** Individual may receive injection: ☐ Yes ☐ No

Vaccine Record **For Administrative Use Only** **(VIS 8/6/21)**

Vaccine	Date Administered	Route	Dose	Manufacturer	Lot #	Exp. Date	Administered By:

☐ Vaccination documented in the EMR on:_____(date) by:_____(initials)

If age 6 months or greater, give Influenza vaccine 0.5 ml IM

Revised 10/14, 11/14, 8/15, 12/15, 6/16, 9/16, 10/16, 9/17, 9/17−1, 8/18, 9/18, 8/19, 9/19, 5/21, 8/21, 9/22

Discrimination is Against the Law

Hays Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Hays Medical Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Hays Medical Center provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Hays Medical Center provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Director of Clinical Care Coordination at 785.623.5297, or the Operator at 785.623.5000.

If you believe that Hays Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Chief Legal Officer
Hays Medical Center
2220 Canterbury Drive
Hays, Kansas 67601
Telephone Number: 785.650.2759
TTY/TDD or State Relay Number: 800.766.3777 (V/T); or Dial 711
Fax: 785.623.5524
Email: joannah.applequist@haysmed.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Joannah Applequist, Chief Legal Officer, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1−800−368−1019, 800−537−7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services are available to you free of charge. Call 1–855-429-7633 (TTY: 1–800-766-3777).

SPANISH
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1–855-429-7633 (TTY: 1–800-766-3777).

VIETNAMESE
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1–855-429-7633 (TTY: 1–800-766-3777).

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1–855-429-7633 (TTY: 1–800-766-3777)。

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1–855-429-7633 (TTY: 1–800-766-3777).

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1–855-429-7633 (TTY: 1–800-766-3777) 번으로 전화해 주십시오.

LAOTIAN
ໂປດຊາບ: ຖ້າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ຊ່ວຍ ເຫລືອ ດ້ານ ພາສາ, ໂດຍ ບໍ່ ເສັຽ ຄ່າ,

ແມ່ນ ມີ ພ້ອມ ໃຫ້ ທ່ານ. ໂທ 1–855-429-7633 (TTY: 1–800-766-3777).

ARABIC
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-429-7633 (TTY: 1-800-766-3777).

TAGALOG
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1–855-429-7633 (TTY: 1–800-766-3777)

BURMESE
သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ဖြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်

စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 1–855-429-7633 (TTY: 1–800-766-3777) သို့ ခေါ်ဆိုပါ။

FRENCH
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1–855-429-7633 (TTY: 1–800-766-3777).

JAPANESE
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます1–855-429-7633 (TTY: 1–800-766-3777)まで、お電話にてご連絡ください。

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1–855-429-7633 (телетайп: 1–800-766-3777).

HMONG
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1–855-429-7633 (TTY: 1–800-766-3777).

PERSIAN (FARSI)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با 1–855-429-7633 (TTY: 1–800-766-3777) تماس بگیرید.

SWAHILI
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1–855-429-7633 (TTY: 1–800-766-3777).

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