Consent Disclosure Statement----------Keep Your Immunization Records Online!

- San Diego Miramar College Student Health Services (SHS), part of the San Diego Community College District, uses the San Diego Regional Immunization Registry (SDIR), a County of San Diego program that is part of the State's California Immunization Registry (CAIR).
- The San Diego Immunization Registry (SDIR) is a computer-based system *only* for authorized medical providers, schools/childcare providers, approved agencies, local health departments in California, and the California Department of Public Health. It is used to track and review immunization information and tuberculosis (TB) test results. The information in SDIR, like other medical information, is protected by law.
- San Diego Miramar College SHS staff will be entering your immunization information and TB test results into SDIR which is a centralized statewide, secure, and confidential database.
- Immunizations and (TB) tests are an important part of healthcare, but keeping track of this information can be difficult for college students who might obtain care from multiple medical providers. By using SDIR, the SHS ensures that your immunization records and TB test results can be easily be located by other health care providers if you have a future need to access this information. Additionally, public health authorities utilize SDIR information for disease management and statistical data which helps protect public safety for a community.
- Students may opt out of the immunization record and TB test results sharing system; to do this the student must sign a SDIR form stating that they request to have their record made confidential. If made confidential, a medical provider must get your signed permission to access your record in SDIR. It's your legal right to agree or refuse at any time to share your immunization/TB test records in a registry.
- For more information, visit the SDIR Website at: www.sdiz.org/CAIR-SDIR/index.html or call the SDIR Help Desk at (619) 692-5656.

Print Student's Name: *LAST NAME, First:* _____ *Middle:* _____ _____	**Student's Date of Birth (MM/DD/YYYY)** / /
Student's Signature and Today's Date: / /	**CSID #**
Mother's Name: ***Mother's Maiden Last Name:*** _____ ***Mother's Fist name:*** _____	
** If the student is ***under 18*** years of age, a parent or guardian must sign giving permission for the student's immunization and TB test data to be entered into SDIR.	
Parent/Guardian (First and Last Name) print):	
Signature of Parent/Guardian:	Today's Date: MM/DD/YYYY)
Name of Student:	Relationship to Student:

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

☐ Kaiser Insurance
☒ Other Insurance

Decline or Start Sharing/ Information Request Form

Email back to SDIR: sdir@sdiz.org

PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY:	
MY FULL NAME:	**RELATIONSHIP TO PATIENT** ☐ self ☐ parent/guardian
Name of Patient:	Patient's Address:
Patient's Date of Birth:	City/Zip Code:
☐ **PERMANENT UNLOCK MY INFO** ☒ **TEMPORARY UNLOCK FOR TODAY**	Phone:

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization record and tuberculosis (TB) test results to be shared with other health care providers, agencies, or schools in the California Immunization Registry.***

** Note: The immunization record may still be recorded in the registry for use by your physician's office. By law, public health officials can also access immunization records and tuberculosis (TB) test results in the case of a public health emergency.*

START SHARING (Declined earlier, now have changed mind and wish to share.)

☒ **I ALLOW my/my child's immunization record and tuberculosis (TB) test results to be shared with other health care providers, agencies, or schools in the California Immunization Registry.**

REQUEST INFORMATION

☐ I REQUEST a list of agencies who have viewed my/my child's immunization registry record.

☐ I REQUEST to review or correct my/my child's immunization registry record. I understand that any changes made to this record must be verified by appropriate documentation from my health care provider.

Signature:	**Date:**

For office use only:
File this form in the patient medical record. Questions? Call SDIR: (619) 692-5656.

First letter of Last Name: _____

Miramar College Student Health Services
Outside Screening Questionnaire for Adult Immunization flu shot
2020-2021

STUDENT ID: _____ **DOB:** _____/_____/_____ **Age:** _____ **Gender:** F ☐ / M ☐
Month Day Year

NAME: _____, _____ **Phone #:**_____
Last First

Address: _____ _____ _____ _____
City State Zip code

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you sick today? Y☐ N☐ Don't know☐
2. Do you have allergies to medications, food, a vaccine component, or latex? Y☐ N☐ Don't know☐
3. Have you ever had a serious reaction after receiving a vaccination? Y☐ N☐ Don't know ☐
4. Have you had a seizure or a brain or other nervous system problem such as Guillain- Barre Syndrome? Y☐ N☐ Don't know☐
5. Have you received any vaccinations in the past 4 weeks? Y☐ N☐ Don't know☐
6. From the Influenza **Vaccine Information Statement page, part 4, you were given today**:
A Flu Shot, might cause any of the following reactions**: swelling where the shot is given, fever, muscle aches, headaches, fainting or dizziness from medical procedures and a small risk of Guillain-Barre' Syndrome (GBS) after receiving inactivated influenza vaccine?** True☐ or False☐

I am requesting a flu shot be administered by the San Diego Miramar College Health Services.

Signature: _____ **Date:** _____

*****FOR OFFICE ONLY*** ---------- *****FOR OFFICE ONLY*** ---------- *****FOR OFFICE ONLY*** ----------

INFLUENZA VACCINE:
Manufacturer: SAP
Fluzone Quadrivalent

Lot #: UT7049KA **EXP: Jun 30 2021**

Vial # N/A

ROUTE/ SITE: IM: LA / RA

Notes as needed:

Reviewed/Dose Given By: Name/Title: _____ **Date Given:** _____

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

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite 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.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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** 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** 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**

ONLY NEEDED IF AGE IS UNDER 18 YEARS OLD AT TIME OF VACCINATION

SAN DIEGO MIRAMAR COLLEGE
STUDENT HEALTH SERVICES

MINOR'S AUTHORIZATION CONSENT FORM FOR MEDICAL TREATMENT

In cases of illness, injury or life threatening emergencies I, _____
(Parent's full name)
Hereby authorize San Diego Miramar College Student Health Services staff to assess and treat

_____.
(Student's full name)

Permission is also granted to provide referral to outside physician and facility, if deemed necessary by health care providers.

This permission doesn't cover special elective procedures requiring local anesthesia (suturing, biopsy, toenail removal). Parent/guardian will be contacted via telephone/ sent consent form for permission to perform these procedures.

Nominal fees may be charged for laboratory, pharmacy and special procedures deemed necessary by health care providers at Miramar College Student Health Services. Payment of these fees will be required at the time services are received.

_____ _____
Parent/guardian signature Parent/Guardian Name (please print)

Date _____ Address _____

Parent Name and Emergency contact phone number _____

Minor's SSN _____ Date of Birth _____ Age _____

Minor's Health Insurance Company _____ Medical Number _____

Minor's Doctor's Name _____ Phone number ___ _____

Please attach a copy of the medical plan ID card.