Affiliated Physician
MDVIP

Viraj V. Tirmal, MD
Internal Medicine

Viraj V. Tirmal, MD LLC

Dear Patient,

The Flu vaccine vaccination is recommended for all patients to provide protection against Flu illness. We currently offer the **Flubok® 2025-2026 (Trivalent Influenza Vaccine)** and the **Fluzone® High-Dose 2025-2026 (Trivalent Influenza Vaccine)** vaccines in our office. Vaccination is especially important for people who are at higher risk of developing serious Flu-related complications if they get sick. This includes people 65 years and older, people of any age with certain chronic medical conditions (such as asthma, diabetes, or heart disease), and pregnant people.

Please answer the following questions to help determine your eligibility for the vaccine today:

	Yes	No
Do you feel sick today (For example: a cold, fever, or acute illness)?	☐	☐
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
Do you have a history of allergic reaction or allergies to vaccines, vaccine components, medications (including injectable therapies), latex, or foods? *Examples: COVID-19 vaccine, polyethylene glycol (PEG), polysorbate, eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein. *This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.*	☐	☐
Have you ever had a severe reaction to any vaccine which required medical care including fainting or feeling dizzy?	☐	☐
Have you received a vaccine in the past 4 weeks?	☐	☐
Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis or pericarditis?	☐	☐
Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies?	☐	☐
Do you have a chronic health condition such as heart disease, chronic lung disease, chronic kidney disease, diabetes, asthma, blood disorder, complement component deficiency, no spleen, a cochlear implant, or spinal fluid leak?	☐	☐
Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?	☐	☐
Do you, or anyone in your home, or anyone you take care of, have a weakened immune system caused by something such as HIV/AIDS, organ transplant, cancer, or take immunosuppressive drugs or therapies? *This includes being treated with prednisone, other steroids, weekly injections, anticancer drugs, or radiation.*	☐	☐
Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	☐	☐
Do you have a bleeding disorder, take a blood thinner, take aspirin or any aspirin-containing products or have a history of Heparin Induced Thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)?	☐	☐
Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐

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Consent

I certify that I am: (i) the Patient; or (ii) the patient's personal representative. I consent to, or give consent for, the administration of the Flu vaccine. I have been provided the patient fact sheet corresponding to the Flu vaccination given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that if a vaccine requires multiple doses, multiple doses of the vaccine will need to be administered. I have been given the opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I have been given the opportunity to ask questions and understand the benefits of vaccination as provided in this document.

I request that the Flu vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccine administration.

I understand if I experience side effects that I should contact the office and/or call 911.

I hereby release Viraj V. Tirmal, MD, LLC and its officers, employees, and agents, respectively, from any and all liability that might arise from this vaccination.

Patient Name (printed): _____

Date of Birth: _____

Patient or Patient's Personal Representative Signature*: _____
**A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient*

Date: _____

Patient Personal Representative Name (printed):

_____

Personal Representative Type: _____

Submit

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