

Influenza (Flu) Vaccine Consent and Liability Form

Flu: Influenza (flu) is a respiratory disease caused by influenza virus infection. The types of influenza virus causing illness may change from year to year, or even within the same year. People who get the flu may have fever, chills, headaches, dry cough and muscle aches and may be sick for several days to a week or more. Most people recover completely. However, for some people, flu may be severely severe, and pneumonia or other complications including death may develop.

Flu Vaccine: The regular flu vaccine contains killed influenza virus of the types selected by the U. S. Public Health Services and the Center for Biologies Evaluation and Research of the U.S. Food Drug Administration. The types of strains of virus included those, which have most recently been causing influenza. The vaccine will **NOT** give you the flu because it is a killed virus vaccine.

Risks and Possible Side Effects: Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm at the injection site, or possibly fever, chills, headaches, or muscle aches. These effects usually last 24 or 48 hours. Most people who receive the vaccine either have none or only mild reactions. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur. Moreover, untoward medical events completely unrelated to vaccine administration may occur coincidentally in the aftermath period following vaccination.

Unlike the 1976 swine influenza vaccine, flu vaccines used subsequently have not been clearly associated with an increased frequency of Guillain-Barre Syndrome, which is associated with paralysis.

Please circle all that apply to you.

1. Are you pregnant? **Yes No** Flu shot should be given at the doctor's office and not at the work place.
2. Are you allergic to eggs, chicken, or chicken feathers? **Yes No**
3. Are you allergic to thimerosal: **Yes No**
4. Have you had a flu shot before? **Yes No**
5. Do you currently have a fever, acute respiratory or other active infections or illnesses? **Yes No**
6. Are you allergic to latex? **Yes No**
7. Have you ever fainted when receiving a shot? **Yes No**
8. Have you ever had a serious reaction to any vaccination? **Yes No**

If you have any questions, please ask now or check with a physician or your health department prior to receiving the vaccine. Otherwise, please remain in the area for 10 – 15 minutes after vaccination to ensure that no immediate reactions occur. If you experience any significant reactions after leaving, contact or see a physician.

I have read the above information about influenza and influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks of influenza and request that the vaccine be given. I hereby release Medical Care Affiliates/Health Promotion Affiliates, its officers, employees and agents; My Employer, its officers, employees and agents from any and all liability that might arise from vaccination on behalf of myself, my heirs, and my personal representatives.

Name (Please Print)			Birth date	Age
Address (Street)	City	State	Zip	
Signature (Person receiving vaccine)				

Clinic Use
Date _____
Clinic Site: _____
Manufacturer: _____
Lot# _____
Site of Injection _____
RN _____