



# Vital Care Health Systems

Where Caring Comes From The Heart

## Annual Influenza (Flu) Vaccination Consent Form

### "Flu"

Influenza (flu) is a respiratory disease caused by influenza virus infection. The types of strains of influenza virus causing illness may change from year to year, or even within the same year. People who get flu may have fever, chills, headache, 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 especially severe, and pneumonia or other complications including death, may develop.

### Flu Vaccine

The regular flu vaccine contains inactive influenza virus of the types selected by the U.S. Public Health Service and the Center for Biologics Evaluation & Research of the U.S. Food and Drug Administration. The types or strains of virus included are those which have most recently been causing influenza. The vaccine will not give you flu because it is made from an inactive form of the virus. As with any vaccine, flu vaccine may not protect 100% of all susceptible individuals.

### Risks & 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, headache or muscle aches. These effects usually last 24 to 48 hours. Most people who receive the vaccine either have no 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.

### Please Circle Your Response

Have you had a flu shot before?	Y	N
When? Month _____ Year _____		
Have you ever had an allergic reaction to a flu shot?	Y	N
Are you allergic to chicken or egg products?	Y	N
Do you feel ill today or do you have a fever?	Y	N
Are you pregnant or think you may be?	Y	N
Do you have a blood clotting disorder or are you taking blood thinning medication?	Y	N

\_\_\_\_\_  
Employee Name / Signature

\_\_\_\_\_  
Witness Name / Signature

### CONSENT FOR VACCINATION

I hereby certify that the foregoing history is true and complete to the best of my knowledge. I have read and understood the information given to me. I have had a chance to ask questions which were answered to my satisfaction. I believe that I understand the benefits and risks of taking the flu vaccine and I request that the vaccine be given to me. I hereby release all sponsors and business associated with the vaccination program from any and all liability associated with the administration and potential side effects of the shots.

### DECLINATION

I understand that I may be at risk to suffer from Influenza during this flu season and that I have been given the opportunity to be vaccinated with Influenza virus vaccine, at no charge to myself. However, I **decline** to receive the "Flu" vaccine at this time.

CHECK ONE: \_\_\_\_\_ I ACCEPT "FLU" Vaccine

\_\_\_\_\_ I DECLINE "FLU" Vaccine

REASON: \_\_\_\_\_

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

Special Notice – Vaccination is generally not recommended for the following people:

1. People allergic to eggs or egg products.
2. People sensitive to Thimerosal.
3. People who have an active neurological disorder.
4. People with a fever, acute respiratory or other active infections or illnesses.
5. Pregnant women in their 1<sup>st</sup> trimester.

**If you experience any significant reactions, see your physician.**

Date \_\_\_\_\_

Date \_\_\_\_\_

### For Office Use Only

Flu Vaccine Lot # \_\_\_\_\_ Exp. \_\_\_\_\_ Date \_\_\_\_\_ Site of Injection: R \_\_\_ L \_\_\_ Deltoid \_\_\_

Administrator \_\_\_\_\_ Signature \_\_\_\_\_