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# FLU VACCINE CONSENT FORM

**The Vaccine:**

The purpose of receiving influenza vaccine is to prevent you from becoming ill with the flu virus, to reduce the severity of flu if you do contract it, and reduce the chance of transmitting flu to close contacts.

**Questions before receiving flu vaccine (circle YES or NO)**

| | | | |
|---|---|---|---|
| 1. | Are you allergic to eggs or egg products? | YES | NO |
| 2. | Are you allergic to mercury? (YES is contraindication to Flulaval) | YES | NO |
| 3. | Are you allergic to latex? (YES is contraindication to Fluarix) | YES | NO |
| 4. | Are you allergic to gentamicin? (YES is contraindication to Flumist) | YES | NO |
| 5. | Do you have a history of Guillain-Barre syndrome? | YES | NO |
| 6. | Do you currently have an acute infection or fever? | YES | NO |
| 7. | Have you ever had a severe allergic reaction to a flu shot in the past? | YES | NO |
| 8. | Are you pregnant or currently nursing a baby? | YES | NO |
| 9. | Do you have a severe blood clotting disorder or are you on blood thinners? | YES | NO |
| 10. | Have you received any other vaccine within the past 14 days? | YES | NO |

*If the answer to any of these questions is "yes", you need to discuss this with your medical provider to determine if you should receive a flu vaccine today and/or which available vaccine brand is the best choice for you.*

**Risks and Possible Side Effects/Reactions**

Flu vaccine cannot give you the flu. Most people have no side effects from the vaccine. A few get a sore arm for a couple of days. Less than 5% of adults will get some achiness or low-grade fever for about a day after vaccination. Very rarely have more serious side effects, such as allergic reaction, been reported.

There is also a possible risk of Guillain-Barre Syndrome (GBS), although recent information does not indicate a clear associated increased risk of GBS in recipients of flu vaccine compared to non-vaccines. Serious reactions should be reported at once to your personal physician.

**BECAUSE OF THE POTENTIAL FOR ALLERGIC REACTION, YOU ARE ASKED TO REMAIN IN THE IMMEDIATE AREA FOR OBSERVATION PURPOSES FOR AT LEAST 20 MINUTES AFTER RECEIVING THE VACCINE.**

**Consent:**

I have read the above information and certify that the above history is true and complete to the best of my knowledge. I have received and read the "Vaccine Information Statement " from the CDC and have had an opportunity to ask questions. I understand the benefits and risks of flu vaccine as described. I request that the vaccine be given to me.

_____ ___/___/___

Patient Name (Please Print) Date of Birth

_____ _____

Signature Witness

**FOR OFFICE USE ONLY**

Manufacturer:_____ Lot #:_____ Expiration: ___/___/___ VIS: ___/___/___

Location:_____ Comments:_____

Administer of vaccine:_____ Date Given ___/___/___