IMMEDIATE HEALTH ASSOCIATES URGENT CARE CENTERS_____.

INFLUENZA VACCINE CONSENT FORM

Influenza (flu) is a respiratory illness caused by an influenza virus, which can be spread by coughing, sneezing or nasal secretions. People who get influenza may develop fever, cough, chills, headache and muscle aches. These symptoms may persist for several days, but could last a week or more. Most people recover completely, but some people may develop pneumonia or other serious complications, including death.

Influenza vaccine contains inactivated viruses of specific strains of influenza, which are predicted by the US Public Health Service and the Center for Disease Control, to be the most prevalent strains of influenza in the coming year. The 2021-2022 vaccine will provide protection against 4 strains of common influenza viruses.

RISKS AND POSSIBLE SIDE EFFECTS

Serious health problems from inactivated vaccine are rare. The most common reactions may be mild soreness, redness or swelling at the injection site, mild fever, body aches, cough, hoarseness and red, itchy eyes. If these problems occur, they usually begin soon after the injection, and may last 1-2 days. Life-threatening allergic reactions to vaccines are rare. Signs of a serious reaction may include breathing problems, hoarseness, hives, pallor, weakness, rapid heart rate and dizziness. These symptoms would occur within a few minutes to a few hours after the injection. If you have a serious reaction to the flu vaccine, call your physician or proceed to the nearest health care facility.

SPECIAL PRECAUTIONS: IF YOU HAVE ANSWERED "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU MAY NOT RECEIVE THE FLU VACCINE UNLESS IT HAS BEEN DISCUSSED WITH THE MEDICAL CARE PROVIDER ON DUTY.

		YES	NO
1.	Are you under 9 years of age?	___	___
2.	Do you have a history of Guillan-Barre Syndrome?	___	___
3.	Are you allergic to eggs?	___	___
4.	Are you sensitive to Thimerosal (preservative)?	___	___
5.	Have you had a previous serious reaction to the flu vaccine?	___	___
6.	Do you currently have an acute infection, illness or fever?	___	___
7.	Are you currently pregnant or breastfeeding?	___	___

PATIENT INFORMATION:

NAME:_____DOB:_____AGE:_____

ADDRESS:_____CITY /
STATE_____ZIP_____

TELEPHONE#_____

I HAVE READ THE ABOVE INFORMATION, AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS. I FULLY UNDERSTAND THE RISKS AND BENEFITS ASSOCIATED WITH RECEIVING THE INFLUENZA VACCINE. I REQUEST THAT THE VACCINE BE GIVEN TO ME OR TO THE PERSON NAMED ABOVE FOR WHOM I AM AUTHORIZED TO SIGN.

SIGNATURE:_____DATE:_____

OFFICE STAFF ONLY: Flucelvax VACCINE Lot #_____Exp date:_____

DATE OF ADMINISTRATION:_____SITE:_____Administered by_____