



# ADULT + PEDIATRIC URGENT CARE

## Influenza Vaccine Consent Form

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_

**You should not receive the influenza vaccine if any of the following apply:**

- You have ever had a serious allergic reaction to eggs, formaldehyde, gelatin, or to a previous dose of influenza vaccine
- You have a history of Guillain-Barre Syndrome
- You are ill

**If it's a child 8yrs old and under and have never received the flu vaccine the child needs to come back in 4 weeks for a second dose.**

**Speak to your doctor if you are pregnant.**

Influenza vaccine is indicated and recommended if your due date falls during the flu season (November to March).

### **Possible Reactions:**

**Mild:** Soreness or redness at the site of the injection, fever and body aches.

**Severe:** Acute allergic reaction-high fever, confusion, difficulty breathing, hives, and rapid heartbeat would occur within a few minutes of the injection

Guillain-Barre Syndrome-progressive muscle weakness and paralysis may occur a week after the vaccine.

This occurs in 1-2 cases per million persons vaccinated.

### **Questions you must answer**

### **Circle your response**

<b>Are you ill today?</b>	<b>YES / NO</b>
<b>Are you allergic to eggs?</b>	<b>YES / NO</b>
<b>Have you ever had Guillain-Barre Syndrome?</b>	<b>YES / NO</b>
<b>Are you allergic to latex?</b>	<b>YES / NO</b>
<b>Have you ever had a severe reaction to formaldehyde?</b>	<b>YES / NO</b>

I have read the current influenza vaccine information sheet. I have been provided the opportunity to ask questions about the disease and the treatment. I understand the risks and the benefits of the vaccination. I understand that the vaccination that I am to receive is a single shot for adults and for children who have received the flu vaccine in the past.

I understand that it will not be fully effective for approximately two weeks. However as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive this vaccine if they have severe allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome. I hereby request the influenza to be given to myself or the person for whom I am authorized to give consent.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Manufacture:** \_\_\_\_\_ **Exp:** \_\_\_\_\_ **Lot:** \_\_\_\_\_

**Dose 0.5cc IM Location R / L Deltoid Administered by:** \_\_\_\_\_ **Date:** \_\_\_\_\_