INFLUENZA IMMUNIZATION INFORMED CONSENT

Influenza is a contagious respiratory illness caused by influenza viruses spread mainly by coughing, sneezing and close contact. The illness can be mild to severe, and at times can lead to death with 80% of influenza deaths impacting adults age 65 and older. According to the CDC, vaccination is the most effective step you can take to be protected from influenza. All influenza vaccines in the United States are anticipated to be Trivalent influenza vaccines formulated to protect against A(H1N1) virus, A(H3N2) virus, and B/Victoria virus. Everyone 6 months and older should get a flu vaccine every season with rare exceptions. Vaccination is particularly important for people who are at higher risk of serious complications from influenza. Please consult your physician/healthcare provider if you have questions or concerns.

HIGH RISK FOR COMPLICATIONS FROM INFLUENZA

- Adults: 65 years and older
- Young children
- Adults and Children with unknown health conditions, such as, asthma, heart disease & stroke, diabetes, cancer, chronic kidney disease, and HIV/AIDS.
- Persons with disabilities
- Persons of racial and ethnic minority groups

CLINICAL INFLUENZA SYMPTOMS

- Chills/sweats
- Dry, persistent cough
- Muscle/body aches
- Sore throat
- Headache
- Runny or stuffy nose
- Fatigue (tiredness)
- Fever over 100°F

POSSIBLE VACCINE SIDE EFFECTS

Mild: Usually short term, 1-2 days

- Soreness, redness or swelling at injection site
- Headache • Hoarseness; sore, red or itchy eyes
- Fever • Aches • Itching • Fatigue • Cough

Severe: Allergic reaction is possible, but very rare

People who are moderately or severely ill should wait until they are recovered before getting the vaccine.

VACCINE INFORMATION STATEMENT (VIS) PROVIDED TO RESIDENT/REPRESENTATIVE

Inactivated Influenza VIS Available at: www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

Vaccine Type Administered: ❑ Trivalent

❍ I have received the information about influenza and have been educated on the benefits and risks associated with the influenza vaccine. I hereby give permission and request the vaccine be administered to me or the person named for whom I am authorized to sign.

_____ _____
Patient/Resident/Legal Representative Date Signed

_____ _____
Witness Signature/Title Date Signed

REASON FOR VACCINE DECLINE (Medical or Personal Reasons)

❍ I have already received this season's vaccine outside the facility. Date received_____ Location_____

❍ I have received the information about influenza and have been educated on the benefits and risks associated with the influenza vaccine. I hereby **decline** my permission to receive the vaccine for the following reason(s):

_____

A. Medication Contraindication(s): Check all that apply (Physician needs to be informed of medical conditions)

❑ Previous Hx of severe reaction to influenza vaccine
❑ Febrile illness at this time (Temp > 101.5° F or 38.6° C)
❑ History of Guillain-Barré Syndrome
❑ Other medical conditions, specify:_____

B. Personal Reason(s): Check all that apply (Physician needs to be informed of personal reasons)

❑ Perceived vaccine ineffectiveness ❑ Fear of needles/injections ❑ Fear of side effects
❑ Perceived vaccine will "give me the flu" ❑ Other personal reasons, specify:_____

_____ _____
Patient/Resident/Legal Representative Date Signed

_____ _____
Witness Signature/Title Date Signed

NAME–Last	First	Middle	MR #

