

# 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         | • Muscle/body aches | • Headache             | • Fatigue (tiredness) |
| • Dry, persistent cough | • Sore throat       | • Runny or stuffy nose | • 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](http://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)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Perceived vaccine ineffectiveness        | <input type="checkbox"/> Fear of needles/injections             | <input type="checkbox"/> Fear of side effects |
| <input type="checkbox"/> Perceived vaccine will "give me the flu" | <input type="checkbox"/> Other personal reasons, specify: _____ |   |

\_\_\_\_\_  
Patient/Resident/Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness Signature/Title

\_\_\_\_\_  
Date Signed

NAME-Last

First

Middle

MR #