Influenza (Flu) Vaccine – Group Immunization

Patient Information:

Flu:
Influenza (flu) is a respiratory disease caused by influenza virus. The types or strains of influenza virus that cause illness may change from year to year, even within the same year. People who get flu may have fever, chills, headache, cough, muscle aches, and may be sick for several days to a week or more. Most people recover completely. However, the flu may be especially severe for some people, and pneumonia or other complications, including death, may occur.

Risks & Possible Side Effects:
Influenza vaccine generally causes only mild side effects that occur at low frequency. Most often, they may be sore or experience tenderness where the injection was given, as well as possible fever, chills, headache, or muscle aches; side effects usually last 24 to 48 hours. Most people who receive the vaccine have no reaction to mild reaction(s). **There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur.** Also, medical events completely unrelated to the vaccine may occur coincidentally following vaccination. I hereby release Farragut Medical and the company sponsoring this event from any and all liability arising from in any way connected with this service.

Please Complete the Screening Questions Below

	Yes	No		Yes	No
Have you had an adverse reaction to any vaccine?			Are you known to be sensitive to Egg(s)/egg products? **(If yes, do not Immunize).**		
Are you known to be sensitive to Thimerosal, a preservative commonly found in eye, ear & nose preparations? **(If yes, do not immunize).**			Are you known to have a history of Guillain-Barre syndrome? **(If yes, do not immunize).**		
Are you acutely ill today (fever>100, coughing, etc.)? **(If yes, do not immunize).**			Do you have any life-threatening allergies?		

If you experience any significant reactions, see your physician.

I have read the accompanying CDC information about the influenza vaccine (VIS), which includes information on related diseases. I have reviewed and answered the relevant screening questions to the best of my knowledge. I have had a chance to ask questions, and I understand that if this is my first time receiving the flu vaccine, I must remain in or near the clinic a minimum of 10 minutes after immunization for the purpose of observation. I am aware that it is my responsibility to report any adverse reactions to the staff before leaving the area and to report any serious adverse reactions to my primary physician after leaving the clinic. In the event that I experience an adverse reaction, I understand that it is my responsibility to follow up with a medical evaluation. I request that the influenza immunization be administered to me.

Name (Please Print) Birth Date

Address

City State Zip Code

Telephone Number

X____
Signature (Person receiving vaccine or Parent /Guardian)

Staff Use Only

Date: ____________________

By: ____________________

Route: (IM)/ Site (Deltoid)

R ☐ L ☐

Manufacturer: ____________________

Lot Number: ____________________