

**PEDIATRIC**

**BANNER CHURCHILL COMMUNITY HOSPITAL**

**INFLUENZA (FLU) VIRUS VACCINE**

**CONSENT FORM**

**2020 - 2021**

Patient Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_ Sex: M [ ]  F [ ]

**INFLUENZA VACCINE:** The viruses that cause flu frequently change, so people who have had flu or received a flu shot in previous years, may become infected with a new strain. Because of this, and because the immunity produced by the flu shot decreases over time, *people should be vaccinated every year*. All the viruses in the vaccine are killed so that they cannot infect anyone. *Vaccine will begin to provide its protective effect after about two weeks, and immunity may decrease on average after several months.* Flu shots will not protect all persons who get them against the flu, or other diseases that resemble the flu.

**POSSIBLE SIDE EFFECTS FROM VACCINE:** Most people have no side effects from recent influenza vaccines. Flu shots are given by injection, usually into the muscle of the upper arm. This may cause soreness for a day or two at the injection site, and occasionally may cause a fever or achiness for one or two days. These flu-like symptoms DO NOT mean you have the flu. Guillain-Barre Syndrome (GBS) is rarely associated with influenza vaccine (1 in 2 million), although a direct relationship has not been established. As with most drugs or vaccines, there is a possibility that allergic or a more serious reaction, even death, could occur with the flu shot.

**QUESTIONS:** If you have questions about influenza or influenza vaccination, please ask or call your doctor or pharmacist before requesting the vaccine.

**REACTIONS:** If anyone receiving the vaccine develops signs of a severe allergic reaction (hives, swelling of the face/throat, difficulty breathing, fast heartbeat, dizziness or weakness), call **9-1-1** and get the person to the nearest hospital. Adverse reactions should be reported to the *Vacci ne Adverse Event Reporting System (VAERS)* website at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or call 1-800-822-7967.

**WARNING: SOME PEOPLE SHOULD CHECK WITH A DOCTOR BEFORE TAKING INFLUENZA VACCINE:**

**MEDICAL HISTORY – PLEASE CHECK YES OR NO**

Have you ever had a serious reaction to a Flu vaccine? Yes [ ]  No [ ]

Do you have a serious allergy to eggs that includes any of the following symptoms: Yes [ ]  No [ ]

 angioedema, respiratory distress, recurrent emesis, required epinephrine or another emergency medical intervention?

Are you currently sick with moderate or severe symptoms, with or without a fever? Yes [ ]  No [ ]

 *If yes, vaccine should be withheld until symptoms resolve.*

Have you ever had Guillain-Barré Syndrome (GBS) within 6 weeks of receiving previous Influenza vaccine? Yes [ ]  No [ ]

 *If yes, further consultation with and vaccine administration from your primary care provider is necessary.*

I choose to be vaccinated against the influenza. I have reviewed the current CDC information sheet about Influenza vaccine provided to me. I have had an opportunity to ask questions and had my questions answered to my satisfaction. I understand the risks and benefits of the vaccine. If I become ill following this vaccination, I agree to report to [x]  **my Primary Care Provider** for evaluation.

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 Signature of person authorized to sign for minor Relationship to minor

Vaccine ID: INFLUENZA

Manufacturer: SEQIRUS **\*\*\*Place sticker here\*\*\***

[x]  AFLURIA QUADRIVALENT PEDIATRIC (6 months to 35 months) 0.25mL

Site of Injection: [ ]  Right Arm [ ]  Left Arm [ ]  Right Thigh [ ]  Left Thigh

Method: [x]  Intramuscular VIS Date: 8/15/2019\_\_ Given to patient on date of injection.

Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name)

Administered Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_