KOHALA COAST URGENT CARE

INFLUENZA (FLU) VACCINE CONSENT

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

Flu Vaccine: The regular flu vaccine contains killed influenza virus of the types selected by the U.S. Public Health Service and the Center for Biologics Evaluation and Research of the U.S. Food Drug Administration. The types of strains of virus included are those which most recently ben causing influenza. The vaccine will NOT give you flu because it is a dead virus vaccine.

Risk & Possible Side Effects: Influenza vaccine generally causes mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm at injection site, or possible fever, chills, headache or muscle aches. These effects usually last 24-48 hours. Most people who receive the either have no or only mild reactions. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur. Moreover, untoward medical events completely unrelated to vaccine administration may occur coincidentally in the aftermath period following vaccine. Unlike the 1978 swine influenza vaccine, flu vaccines used subsequently have not been clearly associated with an increased frequency of Guillain-Barre Syndrome, which is associated with paralysis. Special Notice-check with a physician if vaccination is being considered for:

- Children under 3 years of age
- Pregnant women
- People allergic to eggs, chicken or chicken feathers
- People sensitive to thimerosal (preservative)
- People who have received another type of vaccine during the past 14 days
- People who have an active neurologic disorder
- People with a fever, acute respiratory or other active infections or illnesses

IF YOU HAVE ANY QUESTIONS, PLEASE ASK NOW OR CHECK WITH PHYSICIAN OR HEALTH DEPARTMENT BEFORE RECEVING THIS VACCINE. IF YOU EXPERIENCE ANY SIGNIFICANT SIDE EFFECTS, SEE YOUR PHYSICIAN

I have read the above information about influenza and influenza vaccine and I have had a chance to ask questions. I understand the benefits and risks for influenza vaccination and request that the vaccine be given to me or the person named below for whom I am authorized to sign.

INFORMATION – PERSON TO RECEIVE VACCINE

First Name: _____ Last Name: _____ DOB: _____

*Signature:_____ Date: _____

*Relationship to patient if minor:_____ Signature: _____ *Date:_____

FOR OFFICE USE ONLY

DATE GIVEN: _____ MANUFACTURER: _____LOT #: _____ NDC VIAL: _____

NDC BOX: _____ ROUTE: _IM_ EXP DATE: _____ LEFT / RIGHT ARM INITIAL: _____VAC ENT ☐