WRIGHT STATE UNIVERSITY

Influenza Immunization Consent Form

Name____DOB______________________________

Address____

UID#__________________________________ Phone Number____

Influenza (flu) is a respiratory disease caused by an infection with the influenza virus. The strains of influenza virus which cause 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 a week or more. Most people recover completely. However, for some people, influenza may be especially severe, and pneumonia or other complications, including death, may occur.

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 & Research of the U.S. Food and Drug Administration. The types of virus included are those which have most recently been causing influenza. The vaccine will not give you flu because it is a killed virus vaccine. As with any vaccine, flu vaccine may not protect 100% of all susceptible individuals.

Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm where the injection was given, or less frequently, possible fever, chills, headache, or muscles aches. These side effects usually last 24 to 48 hours. Most people who receive the vaccine either have no reaction or only mild reactions. There is a possibility, as with any vaccine or drug that an allergic or other service reaction, or even death, could occur.

Please answer the following questions:

Question		
Are you presently ill or had a fever in the past 3 days?	YES	NO
Do you suffer from immune deficiency disease?	YES	NO
Do you have a clotting or bleeding disorder?	YES	NO
Do you have any type of neurological disorder?	YES	NO
Have you ever had an allergic reaction to:	YES	NO
Vaccines or immunizations?	YES	NO
Eggs or egg products?	YES	NO
Neomycin?	YES	NO
Are you receiving steroids, chemotherapy or radiation therapy?	YES	NO
Are you pregnant or nursing and infant?	YES	NO
Have you ever had Guillain Barre?	YES	NO

If you have any of the above, please notify the staff or check with your physician before receiving the vaccine. **If you experience any significant reactions, see your physician.**

I have read the Vaccine Information Sheet (VIS) and had a chance to ask questions. I understand the benefits and risks of influenza vaccination and request the vaccine be given to me, or the person named below for whom I am authorized to sign.

Signature: ____Date: __________________________

FOR CLINIC USE ONLY:

Name of Clinic:	**Site of Injection:**
Date of Vaccination:	**Signature of Nurse:**
Manufacturer/ Lot No/ Expiration Date:	