

# CONSENT FOR INFLUENZA VACCINE (2009)

## What is influenza and what are the risks?

Influenza is a serious respiratory disease that is caused by a virus. People who get influenza have a cough, fever, chills, sore throat, headache, muscle aches and fatigue. The cough and fatigue can persist for several weeks, making the return to full personal and work activities difficult.

Influenza spreads easily from infected persons to the nose and throat of others through coughing and sneezing.

## Benefits of influenza immunization

People who have heart disease, cancer, kidney disease or are over age 65 are at a high risk for complications from influenza and should be immunized. The vaccine is 70-90% effective in preventing influenza in healthy adults.

## Risks of influenza immunization

Most people who receive the influenza vaccine have either no side effects or mild side effects. This may include soreness, redness and swelling at the injection site.

A small number of people may get a fever or muscle aches shortly after getting the influenza vaccine and it may last 1 to 2 days. As with any vaccine, there is a remote possibility that a more serious reaction could occur.

It is recommended that an individual who developed Guillain Barré syndrome within 6 to 8 weeks of a previous influenza vaccine not be immunized at this time. Please follow-up with your family physician.

An increased number of reports of a mild self-limiting reaction occurred a few years ago. Symptoms included red eyes, cough, sore throat, wheezing and tightness of the chest. People with moderate to severe illness may have to delay immunization.

If you have had a reaction to a vaccine in the past, discuss with the vaccine provider.

People who take oral theophylline or oral anticoagulants should consult with their physician.

**If you are allergic to eggs or Thimerosal you should not have influenza vaccine.**

**I have read the above and consent to have influenza vaccine.**

Seasonal Flu \_\_\_\_\_ H1N1 \_\_\_\_\_ Both Seasonal and H1N1 \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

DEPARTMENT/AGENCY/COMMISSION \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Health card # \_\_\_\_\_

DATE: \_\_\_\_\_

HIGH RISK? YES  NO