



Influenza Consent Form & Vaccine Administration Record

The Flu -- Influenza is a respiratory infection caused by viruses. When people get the flu, they may experience a fever, chills, headache, dry cough, or muscle aches. Illness may last several days or a week or more and complete recovery is usual. However, complications may lead to pneumonia or death in some people.

The Vaccine -- An injection of the flu vaccine will not give you the flu because the injectable vaccine is made from a dead virus. We recommend that you remain on site for up to 15 minutes following vaccine administration to monitor for possible vaccine reactions. For the best results, the vaccine is to be administered in the months of October or November. However, since the flu season typically peaks between January and March, getting vaccinated in December or later can be beneficial.

Risks and Possible Side Effects -- Side effects of the influenza vaccine are generally mild in adults and occur at low frequency. **Reactions for the injectable vaccine include:** soreness, redness, or swelling at the injection site, fever; and muscle aches. These symptoms usually begin soon after the shot and last 1 to 2 days. An immediate, possible allergic reaction rarely occurs after a flu vaccination. This is likely due to an allergy to some vaccine component, of which the majority are most likely related to residual egg protein. Unlike the 1976 Swine influenza vaccine, subsequent vaccines prepared from other virus strains have not been clearly associated with an increased frequency of Guillain-Barre syndrome.

Special Precautions -- Children, pregnant women, and persons with serious illness should consult their physician before receiving the influenza vaccine.

Persons who are allergic to eggs or egg products should not receive this vaccine without consulting their physician.

Persons who are ill and have a fever should delay vaccination until the fever and other symptoms have subsided.

Persons who have received another type of vaccine within the past 14 days should see their physician before receiving this vaccine.

Persons who are allergic to latex should notify the provider prior to receiving this vaccination.

DO NOT receive this vaccine if you have had or are at risk for Guillain-Barre syndrome.

DO NOT receive this vaccine if you have had a serious reaction to the flu vaccine in the past.

INFORMATION CONCERNING PERSON TO RECEIVE INFLUENZA VACCINE:

NAME (please print)	DATE OF BIRTH	AGE	PHONE NUMBER
ADDRESS	CITY	STATE	ZIP
DO YOU HAVE ALLERGIES TO: <input type="checkbox"/> Eggs or egg products <input type="checkbox"/> Flu vaccine		ARE YOU PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No	

NAME & ADDRESS OF FAMILY PHYSICIAN

CONSENT:

I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of the flu vaccination as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

SIGNATURE OF PERSON RECEIVING or AUTHORIZING VACCINE

DATE

MEDICARE RECIPIENTS PLEASE COMPLETE THE SECTION BELOW:

Please check one:

I hereby authorize the Pharmacy to bill Medicare Part B on my behalf. I request that payment of authorized Medicare benefits be made to the pharmacy for **Influenza Virus vaccine and its administration** as furnished to me by the pharmacy. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.

I hereby attest that as of the date indicated above, I am **not enrolled in Medicare Part B.**

Vaccination Information (office use only)			
Aventis / Evans / FluMist Lot #:		Exp. ___/___/___	
Dose: 0.5mL 0.25mL	Amount Paid: _____		
Admin. Site: R L Arm Thigh Intranasal			
Signature & Title of Vaccine Administrator: _____			
Date Administered: _____			



Medicare Health Insurance Claim Number (HICN): _____