

H1N1 Influenza Vaccine Consent

Patient Name: _____ Date: _____

Birth Date: _____ SS # _____

Have you had the flu vaccine before? _____no _____yes _____don't know

What is the “flu”? A respiratory disease caused by a virus that produces fever, chills, headache, dry cough and muscle aches. A person may be sick for several days to a week or more. Most people recover completely. However, flu may be especially severe in some people and pneumonia or other complications including death may develop.

What is the “flu vaccine”? An influenza virus vaccine. Since the types of influenza virus change from year to year, the U.S. Public Health Service in conjunction with other research agencies, determine which specific strains of virus to include in the vaccine each year. The vaccine does not offer 100% immunity, but significantly reduces the chances of contracting a serious illness.

Side Effect: Most people have no difficulty with the flu vaccine. A slight local reaction of soreness at injection site (arm), low grade fever, or muscle aching may occur. As with any vaccine or drug, there is a possibility of an allergic or other serious reaction, or even death, could occur. Occasionally, other medical events completely unrelated to vaccine administration may occur coincidentally. Unlike the 1976 swine influenza vaccine, flu vaccines used since then haven't been clearly associated with Guillain-Barre Syndrome, which involved paralysis.

Special Notice: Please let your physician or the nurse know if you:

1. Have an allergy to eggs or a reaction when you eat eggs or to a previous dose of influenza vaccine
2. Have an allergy to Thimerosal – or any vaccine component.
3. Have an active neurological disorder
4. Have a fever, acute respiratory or other active infection or illness
5. Have a history of Guillain-Barre Syndrome.
6. An active bleeding disorder or on anticoagulant therapy.

If you have any questions or concerns or are pregnant, please contact your doctor.

CDC H1N1 Influenza VIS Offered – Initial _____

I have read the above information and believe I understand the benefits and risks of this vaccine. I request that the vaccine be administered to me. I release Memorial Health System, Inc. and its employees from any and all liability related to this treatment. I request that payment of authorized Medicare, Medicaid or Insurance benefits be made for services furnished, I authorize any holder of medical or other information necessary to determine these benefits or related services to be released to the carrier and its agents.

Signature of the Patient or the Patient's Legal Representative _____ Date _____

FOR OFFICE USE ONLY

Dose	Site	Manufacturer Sanofi Pasteur	Lot #	Exp. Date
Date	Signature & Title of Person Administering			