Hawarden Regional Healthcare

Seasonal Influenza Vaccine Consent Form 2021-2022

Print Name: _____ **Date of Birth:** _____
Address: _____ **Town/State/Zip Code:** _____
Phone number:

_____

Insurance name: _____ ID number: _____ Group: _____

Yes No	
	1. Are you currently ill and have a fever greater than 101 degrees?
	2. Are you allergic to eggs?
	3. Have you ever had a severe reaction to the flu vaccine?
	4. Have you had Guillian-Barre Syndrome?

You should not receive the Influenza vaccine if you have ever had a serious allergic reaction to a previous dose of influenza vaccine; you have a history of Guillain-Barre Syndrome (GBS); you are ill. An egg-free alternative may be available; please ask about this.

If you have had recent chemotherapy, radiation therapy, or steroids these conditions may decrease the effectiveness of the vaccine. However, flu vaccination is still recommended. Flu vaccination is recommended for any woman who will be breastfeeding during the influenza season, or will be pregnant during the influenza season. Vaccination can occur in any trimester.

Possible reaction(s):
Mild: Soreness or redness at the site of the shot; fever; body aches.
Severe: Acute allergic reaction – high fever; confusion; difficulty breathing; hives; rapid heartbeat (would occur within a few minutes of the shot). Guillain-Barre Syndrome – progressive muscle weakness and paralysis – may occur a week after the vaccine (occurs in 1-2 cases per million persons vaccinated).

I understand that the usual post-inoculation reactions are all that may normally be anticipated and I will take the responsibility to seek medical attention should more severe symptoms occur.

Consent

I have read the Influenza vaccine information sheet dated 8/6/2021. I have been provided an opportunity to ask questions about the disease and the treatment. I understand the risks and benefits of the vaccination. I understand that the vaccination that I am about to receive is a single shot and it will not be fully effective for approximately two weeks. However, as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that I should not receive this vaccine if I have had a severe reaction to a previous influenza vaccine, or if I have had Guillain-Barre Syndrome. I hereby release Hawarden Regional Healthcare from all responsibility for reactions that may occur from this immunization against influenza. I hereby consent to have the influenza vaccine.

Signature of Vaccine Recipient or Parent/Guardian: _____

If Parent/Guardian, please print name: _____

Date: _____

For office use only:
Name of flu vaccine: _____ Dose: _____ NDC: _____
Lot #: _____ Expiration Date: _____Date of Administration: _____
Location (circle): Right Deltoid Left Deltoid Administered by: _____
Right Thigh Left Thigh