



## Influenza Vaccine Consent Form 2019-2020

I have read, or have had explained to me, the CDC Vaccine Information Statement about influenza and the influenza vaccine. I understand that this vaccine may cause flu-like symptoms in some people and in rare incidents Guillain-Barre Syndrome. I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me (or person named below for whom I am authorized to make this request).

**You should not receive the influenza vaccine if any of the following apply:**

- You have ever had a serious allergic reaction to eggs, formaldehyde, gelatin, or to a previous dose of influenza vaccine.
- You have a history of Guillain-Barre Syndrome (GBS).
- You are ill.

**Possible reactions:**

**Mild:** Soreness or redness at the site of the shot, fever, and body-ache.

**Severe:** Acute allergic reactions such as high fever, confusion, difficulty breathing, hives, and 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. This occurs in 1-2 cases per million people vaccine.\*\*

**Please answer the following questions:**

- |  |          |
|--|----------|
| 1. Do you have fever or/and cold-like symptoms?            | Yes / No |
| 2. Are you currently taking immunosuppressive medications? | Yes / No |
| 3. Are you currently taking aspirin?                       | Yes / No |
| 4. Are you allergic to eggs?                               | Yes / No |
| 5. Have you ever had a reaction to a flu vaccine?          | Yes / No |
| 6. Have you had Guillain-Barre Syndrome?                   | Yes / No |
| 7. Are you allergic to latex?                              | Yes / No |
| 8. Have you ever had a severe reaction to formaldehyde?    | Yes / No |
| 9. Have you ever had a severe reaction to gelatin?         | Yes / No |
| 10. Are you under the age of 3?                            | Yes / No |

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_