INFLUENZA IMMUNIZATION CONSENT FORM

FAX 613-961-2546

Influenza is a respiratory infection caused primarily by influenza A and B viruses. In Canada, influenza generally occurs each year in the late fall and winter months. Symptoms typically include the sudden onset of high fever, cough and muscle aches. Other common symptoms include headache, chills, loss of appetite, fatigue and sore throat. Nausea, vomiting and diarrhea may also occur, especially in children. Most people will recover within a week or ten days, but some are at greater risk of more severe complications, such as pneumonia. People with chronic diseases may have worsening of their underlying disease. The vaccine will not give you influenza because it is a "killed virus" vaccine.

Possible Side Effects:

The influenza vaccine has been shown to be extremely safe with no significant side effects. The vaccine has not been associated with any neurological changes since 1976.
Most people have no side effects. Occasionally 6 – 12 hours after receiving the vaccine some may experience redness and tenderness at the site of injection, or slight fever, headache or fatigue for 1 to 2 days.
Serious reactions have not been reported. Should one occur, seek immediate medical attention.

YES___ **NO**___ Have you had any previous reaction to the influenza vaccine or any other vaccine such as hives; swelling of face, mouth or throat; bilateral red eyes; cough; sore throat; wheezing, etc?
YES___ **NO**___ Do you have a fever, respiratory or other active infectious disease at this time?
YES___ **NO**___ Do you have an active neurological condition or one that is unstable, under investigation or changing? (i.e. Multiple Sclerosis)
YES___ **NO**___ Did you develop Guillain-Barre Syndrome within six weeks of receiving the influenza vaccine?
YES___ **NO**___ Did you develop Oculo-Respiratory Syndrome (ORS – bilateral red eyes and/or respiratory symptoms) within 24 hours of receiving the influenza vaccine?
YES___ **NO**___ Do you have a known sensitivity to Formaldehyde, Ethanol, Thimerosal, (a preservative used in many vaccines or contact lens solution), Aluminum, Sucrose, Sodium deoxycholate or Yeast?
YES___ **NO**___ Do you have a known sensitivity to: Gentamycin or Neomycin and Polymixin B.
YES___ **NO**___ Do you have multiple allergies?

Are you taking any of the following medications?
YES___ **NO**___ Beta Blockers. People on high doses or beta blockers may not respond to adrenalin as quickly if needed
YES___ **NO**___ Any drug to thin your blood (anticoagulant) i.e. Coumadin or Warfarin (not Aspirin)

I have read and understood information provided to and my questions have been answered to my satisfaction.
I authorize any Registered Nurse (RN), Registered Practical Nurse (RPN), Nurse Practitioner (ECRN) or Physician from Quinte Health Care or CBI Health to give me an injection of the Influenza Vaccine.
I agree to remain in the hospital post vaccination, to be observed for any reaction.
I agree to seek immediate medical attention, if I should develop any health problems following the vaccination such as *hives, facial swelling, difficulty breathing or swallowing, high fever, seizures, or muscular weakness*.
I will report any serious side effects such as *hives, facial swelling, difficulty breathing or swallowing, high fever, seizures, or muscular weakness, arthritis or brain diseases (Encephalitis)* to my treating health care practitioner and the local Public Health Unit.

Client's Name (print): _____ Date of Birth: _____ Age: _____

Job Title (e.g.: RN, MD, HSR): _____ Job Location: _____

VACCINE:
[ ] Flulaval Tetra (manufacturer Glaxo Smith Kline) Lot #: _____ Expiry date: _____
[ ] Fluzone Quadrivalent (manufacturer Sanofi Pasteur) Lot #: _____ Expiry date: _____
[ ] Fluzone High Dose (manufacturer Sanofi Pasteur) Lot #: _____ Expiry date: _____
[ ] Fluad Trivalent (manufacturer Seqirus) Lot #: _____ Expiry date: _____
[ ] Flucelvax Quadrivalent (manufacturer Seqirus) Lot #: _____ Expiry date: _____

IM Deltoid Injection L: _____ R _____ Date: _____ Fact Sheet Provided: Y N