Influenza Consent Form

The Flu- Influenza is a respiratory infection caused by viruses. When people get the flu they may have 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 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 best results, the vaccine is to be administered in the month of October. However, since the flu season typically peaks between January and March, vaccination in December or even later can be beneficial.
Risks and Possible Side Effects- Side effects of influenza vaccine are generally mild in adults and occur at a low frequency. Reactions to 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, presumably allergic reaction rarely occurs after a flu vaccination. This probably results from an allergy to some vaccine component of which the majority is 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 a 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 their provider prior to receiving this vaccine.
DO NOT receive this vaccine if you have had or are at risk of Guillian-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: _____ Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Name of Primary 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 vaccination be given to me.

Signature: _____ Date: _____

Acknowledgement of Notice of Privacy Practices: I have received a Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by MediCenter Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature: _____ Date: _____

Medicare Recipients complete the section below (Please check one).

☐ I hereby authorize MediCenter Pharmacy to bill Medicare Part B on my behalf. I request that payment of authorized Medicare benefits be made to MediCenter Pharmacy for the influenza vaccine and its administration as furnished to me by Medicare Pharmacy. I authorize my information needed to determine these benefits payable for related services.

☐ I herby attest that as of the date indicted above. I am not enrolled in Medicare Part B.