**FLU VACCINE CONSENT FORM**

I voluntarily submit to and authorize GREAT RIVER PEDIATRIC CLINIC to administer the flu vaccine to my child for the purpose of immunizing against influenza and have reviewed the Vaccine Information Statement. I have had a chance to ask questions and understand the information presented to me.

I understand that if this is not a covered service under my insurance, that I will be responsible for the cost.

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| **Inactivated Influenza Vaccine** | **Intranasal Influenza Vaccine** |
| **Contraindications:**   * A history of an allergy to egg products or gelatin * Acute respiratory illness with a fever * A history of Guillian-Barre Syndrome or active * neurological disorder * Currently on long-term steroids * Sensitivity to latex   I understand that occasional reactions may occur and these may include:  **Local reactions**: soreness at the vaccine site  **Systemic reactions**: fever, aches **Immediate or allergic reactions:** In rare cases a serious allergic reaction may occur. Signs of a serious allergic reaction may include difficulty breathing, hoarseness or wheezing, hives, paleness weakness, a fast heartbeat or dizziness.  I have read the contraindications above and have discussed any concerns with my healthcare provider.  I understand that I am to report to the nearest Emergency Department if a severe reaction occurs.  Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Signature:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Contraindications:**   * People with asthma or have had wheezing in the past 6 months * A history of an allergy to eggs or egg products * People who have long-term health problems * People with weakened immune system * Children or adolescents on long-term aspirin treatment * A history of Guillian-Barre Syndrome or active neurological disorder * Pregnant women * People who are moderately or severely ill * Under 2 years old or over 49 years old * People with close contact with a person who is severely immuocompromised * Received other vaccinations in the past 4 weeks.   I understand that occasional reactions occur. These may include: **Systemic reactions:** In children and adolescents 2 17 years of age, mild reactions including runny nose, nasal congestion or cough, headache and muscle aches, fever, abdominal pain or occasional vomiting or diarrhea may occur. Some adults 18 -49 years of age have reported runny nose or nasal congestion, sore throat, cough, chills, tiredness/weakness, and headache.  **Immediate allergic reactions:** In rare cases, a serious allergic reaction may our. Signs of a serious allergic reaction may include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat or dizziness.  I have read the contraindications above and have discussed any concerns with my healthcare provider.  I understand that I am to report to the nearest Emergency Department if a severe reaction occurs.  Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |