Riverside Health
Medical Group

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INFLUENZA VACCINE CONSENT & RELEASE

Influenza is a viral infection resulting in a combination of symptoms including fever, sore throat, cough, fatigue and body aches. The infection can be more severe by invading the lungs and causing pneumonia. Influenza vaccine is given to prevent certain types of flu. However, it is not effective on all types of flu. Annual vaccination is recommended for all people who are at a higher-than-average risk for or from infection.

Possible Side Effects include, but are not limited to:

- Slight to moderate tenderness and redness at the injection site
- Fever, fatigue, and body aches within 6-12 hours after injection and lasting 1-2 days
- Immediate allergic reaction including hives, breathing difficulty, swelling around lips, eyes, and tongue
- Rare serious side effects including death are possible

Precautious:

- Inform the doctor or nurse of any history of Guillain-Barre disease, or if you have any respiratory infection symptoms at the present time.
- Flu vaccine *should not be given* at the same time as a **DPT** or within 14 days of an **MMR shot or live measles vaccine.**

PLEASE PRINT CLEARLY:			
Patient Name:		DOB:	Date:
Address:		Phone #	
City:	State:		Zip:
Email:		Gender:	Age:

☐ Yes ☐ No Fever within 24 hours of 100.4 or over?

☐ Yes ☐ No Are you currently ill?

☐ Yes ☐ No Have you ever had an adverse reaction to a Flu shot?

If you answered **YES** to any of the above questions, please explain:

_____

NOTICE AND CONSENT *(Participation in this flu vaccine program is strictly voluntary.)*

Certain side effects of the influenza vaccine are possible. They are generally mild in adults and occur infrequently and are more common in children. Tenderness, redness and swelling at the injection site along with general achiness can last one to three days. In ten cases out of one million, an often-reversible paralysis can occur. Allergic reactions, if any, are usually immediate.

In addition to the side effects described above, there is no guarantee that there cannot be other harmful side effects, including death. My signature below shall serve as my consent to this vaccination, and I hereby release Riverside Medical Group, and the health professionals administering this program from any liability resulting from the program.

PRINT NAME: _____

SIGNED: _____ DATE: _____

(Individual or Parent/Legal Guardian or Legal Representative)

*Current CDC Flu Information Sheet available upon request.

OFFICE USE ONLY:

Type	Date	LOT#	Site		Administrator Initials
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