CENTRASTATE HEALTHCARE SYSTEM

AUTHORIZATION FOR ADMINISTRATION OF FLU VACCINE

PRINT YOUR NAME LEGIBLY: _____

ADDRESS:_____

AGE: _____ SEX: MALE_____ FEMALE:_____

Some people should not be vaccinated. Contraindications include **severe allergy to eggs** (vaccine influenza is grown in hens' eggs) or any other vaccine component (i.e. **thimerosal, a mercury containing organic compound widely used as a preservative in many biological and drug products, including certain vaccines and contact lens solutions)** and having a moderate or severe illness with fever at time of vaccination (not including minor illness). Sensitivity to latex should also be considered since vial stoppers may include it. Also, not that, if your immune system is compromised by illness at the time of vaccination, your body may not be able to respond as it should to build up antibodies for protection against the flu. **The most common side effect of the flu shot is soreness at injection site, which can last up to two days but does not usually affect an individual's ability to perform normal daily activities.** Life-threatening allergic reactions, which usually occur immediately, are very rare but possible in individuals allergic to any vaccine components.

1. **Have you ever had a flu shot before?** **___YES** **___NO**
2. **Are you allergic to eggs or egg products?** **___YES** **___NO**
3. **Are you allergic to thimerosal?** **___YES** **___NO**
4. **Have you ever had an allergic reaction to flu or other vaccines?** **___YES** **___NO**
5. **Is there a chance you are pregnant?** **___YES** **___NO**

The flu shot is considered safe for pregnant women, breastfeeding women and their infants. It is recommended for women who will be pregnant during the flu season since they are at increased risk for flu related complications. Please consult your physician prior to receiving the vaccine.

6. **Are you currently sick (does not include minor illnesses)?** **___YES** **___NO**
7. **Are you allergic to latex?** **___YES** **___NO**
8. **Do you have a history of Guillain-Barre Syndrome?** **___YES** **___NO**
9. **Do you have a history of Multiple Sclerosis?** **___YES** **___NO**
10. **Are you allergic to epinephrine or benadryl? (drugs used to counteract an allergic reaction to the flu shot)** **___YES** **___NO**
11. **Are you taking coumadin or another prescription blood thinner and/or theophylline preparations?** **___YES** **___NO**

I understand that the recommended immunization is one injection/dose. I understand that receiving the vaccine does not protect me against other illnesses that resemble the flu and it may not completely protect me against the flu. **Influenza vaccine CANNOT cause influenza.** I accept that services might be rendered in a non-private setting. I agree to remain at the clinic for at least 5-10 minutes after vaccination if it is my first time being vaccinated. A Vaccination Information Sheet has been made available to me and I have been provided with the opportunity to ask questions related to the vaccine. I hereby release Centrastate Healthcare System of any responsibility for ill effects. I hereby consent to the flu vaccine.

SIGNATURE:_____DATE:_____

For staff use only:

0.5 ml IM R___ L___ Deltoid Fluzone Lot# UH181AC exp. date: 6/30/11

Signature of vaccine administrator:_____