



IMPORTANT INFORMATION FOR PATIENTS WISHING TO RECEIVE FLU VACCINATION

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). **Talk to a doctor before being vaccinated** if you are allergic to eggs or other vaccine components, have ever had an allergic reaction to a flu shot or similar vaccine, or developed Guillain-Barre syndrome (GBS), a severe paralytic illness, within six weeks of getting a flu shot in the past. Latex sensitivity should be considered with flu vaccination and the items used to administer the vaccine. The vaccine is not approved for children under 4 years of age. Note 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 the injection site**, which can last up to two days but does not usually affect an individual's ability to perform normal daily activities. Some people, usually children and others who have not been exposed to the influenza viruses before, may notice "mild" flu-like symptoms, such as fever, malaise, and muscle weakness after receiving a flu shot. Symptoms usually start 6 to 12 hours after vaccination and can last up to two days. **Less common side effects include allergic reactions and Guillain-Barre syndrome (GBS).** Life-threatening allergic reactions, which usually occur immediately, are very rare but possible in individuals allergic to any vaccine component. The 1976 Swine flu vaccine was associated with an increased incidence of GBS. Since then, the risk is estimated to be very low at 1 to 2 cases per million vaccinated, which is much less than the risk of getting the flu.



Name: _____ Date: _____

Address: _____
Street City State ZIP

Phone: _____ Birthdate: _____ Sex: M _____ F _____

Questions

	Yes	No
1. Have you had a flu shot before?	_____	_____
2. Are you allergic to thimerosal-containing products?	_____	_____
3. Are you allergic to chicken, eggs or egg products?	_____	_____
4. Have you ever had a reaction to flu or other vaccine?	_____	_____
5. Is there a chance you are pregnant?*	_____	_____
6. Are you currently sick (do not include minor illness)?	_____	_____
7. Do you have a history of Guillain-Barre Syndrome?	_____	_____
8. Are you allergic to rubber or latex products?	_____	_____
9. Are you interested in the shingles vaccine?	_____	_____

*The flu shot is considered safe for pregnant women, breastfeeding women and their infants and is recommended for women who will be pregnant during flu season since they are at increased risk for flu-related complications. However, it is NOT ADVISED to administer flu shots from a multi-dose vial to pregnant women (and children) because of their levels of thimerosal.

I have received and read the information sheet for the flu vaccination I wish to receive and have had the opportunity to ask questions which were answered to my satisfaction. I accept that services might be rendered in a non-private setting. I agree to remain at the pharmacy for at least 10 minutes after vaccination if it is my first time being vaccinated. I hereby consent to the administration of the flu vaccine to myself or the person named below for whom I am authorized to make this request. Furthermore, I hereby release and forever discharge myself, my heirs, executors, administrators and assignees, U Save and their employees, owners and representatives from any and all claims, demands, actions and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

I understand that I will be responsible for the cost, if insurance/Medicare does not cover this injection.

Signature: _____

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For U Save Rx use only

Date vaccinated _____ Date on VIS _____ Date VIS given _____

Mfr _____ Lot # _____ Exp Date _____ Inject site RD LD

Administered by: _____ Check/Cash Medicare B No fee