



2019-2020 INFLUENZA VACCINE CONSENT FORM

Name: _____ Date of Birth: _____

Are you currently a patient of WVU Medicine? YES or NO

Are you a currently a WVU Medicine employee?* YES or NO

***If you are a WVU Medicine employee, please request a copy of this form and fax to WVUMedicine Employee Health at 304-598-4957 to satisfy the 2019/2020 Influenza Vaccine requirement**

Please complete the following screening questions:

YES NO

- ___ ___ 1. Are you 18 years of age or older?
- ___ ___ 2. Have you ever had a severe reaction to a flu shot?
- ___ ___ 3. Are you allergic to eggs?
- ___ ___ 4. Are you allergic to Formaldehyde?
- ___ ___ 5. Are you experiencing acute illness symptoms or have a fever?
- ___ ___ 6. Do you have a medical condition or are you taking medications that suppress your immune system?
- ___ ___ 7. Have you ever had Guillain-Barre syndrome or other neurologic disorder?
- ___ ___ 8. Are you pregnant or breastfeeding?

I have been offered the Inactivated Influenza Vaccine **WHAT YOU NEED TO KNOW 2019-2020 Vaccine Information Statement** sheet. I have had the chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and ask that it be given to me or the person named below for who I am authorized to make this request.

Signature _____ Date _____

CLINIC USE
ONLY

Date Administered: _____		Injection Site: R or L deltoid	
Vaccine Manufacturer: _____			
LOT#: _____	NDC#: _____	Exp Date: _____	
Signature of Vaccine Administrator			

Understanding the Screening Questionnaire and Additional Information about Influenza vaccine

About flu vaccines: There are two types of vaccines that protect against the flu. The "flu shot" is an Inactivated vaccine (containing killed virus) that is given with a needle in the arm. Because the virus is killed, it is NOT possible to get the flu from the vaccine.

Have you ever had a severe reaction to a flu shot? The vaccine should not be given with a severe allergic or anaphylactic response to a previous influenza vaccine. Severe reactions occur within minutes to hours following the vaccination. Localized soreness, redness, swelling, pain, fever and aches are considered mild problems and are not contraindication for receiving the vaccine.

Are you allergic to eggs? Allergy to eggs is a contraindication. Persons with egg allergies should NOT receive vaccine.

Are you experiencing acute illness symptoms or have a fever? There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccinations. Do not withhold vaccination if a person is taking antibiotics.

Do you have a medical condition or are you taking medications that suppress your Immune system? Medical conditions that suppress the immune system include; acquired or congenital immunodeficiency, chronic metabolic diseases, renal dysfunction and hemoglobinopathies. These conditions may decrease the effectiveness of the influenza vaccine. But they also increase the risk of complications due to Influenza. Immunosuppressive medications may compromise the body's response to the influenza vaccination. Please consult with a health care provider to see if flu vaccination is recommended for you.

Have you ever had Guillain-Barre` syndrome or other neurologic disorder? Guillain-Barre` Syndrome (GBS) is a disorder in which the body's immune system attacks part of the peripheral nervous system. Incidence of GBS among the general population is low, but persons with a history of GBS have a substantially greater likelihood of subsequently experiencing GBS than persons without such a history.

Reasons to defer Influenza vaccine and consult with health care provider include: Guillain-Barre syndrome within 6 weeks after a previous vaccination, or progressive neurological disorder, including encephalopathy or uncontrolled seizure not attributable to an identified cause. Influenza vaccine administered in the 1970s may have increased the risk of GBS. This association has not been shown since then. The low estimated risk of GBS is much less than that of severe influenza that could be prevented by immunization.

For women: Are you pregnant or breastfeeding? Pregnant women should receive only inactivated Influenza vaccine.

References:

1. Prevention and Control of Influenza. Recommendations of the Advisory Council on Immunization Practices (ACIP) MMWR June 28, 2006/55 (Early Release): 1-41

2. Influenza Vaccination of Health-Care Personnel. Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP). MMWR February 9, 2006/55

3. Inactivated Influenza Vaccine: What you need to know. 2006-07.

4. <http://www.fda.gov/CBER/vaccine/thimerosal.htm>



Flu Vaccine Information Form

NON-PEIA

*Please bring a copy of both sides of your insurance card

Patient Information:

Name: _____ Birth Date: _____

Address, City, State, Zip: _____

Phone Number: _____ Social Security Number: _____

Circle One: MALE or FEMALE

Emergency Contact Information:

Name: _____

Home Phone Number: _____ Cell Phone Number: _____

Relationship to Patient: _____

Contact if ever admitted to West Virginia University Hospital or Emergency Department? YES / NO

Insurance Information:

Insurance Holder (Subscriber): _____

Insurance Name: _____

Subscriber Birth Date: _____ Subscriber Social Security Number: _____

Subscriber Address, City, State, Zip: _____

Subscriber Phone Number: _____ Subscriber Employer: _____

ID Number: _____ Group Number: _____



Flu Vaccine Information Form

PEIA Members

*Please bring a copy of both sides of your insurance card

Patient Information:

Name: _____ Birth Date: _____

Address, City, State, Zip: _____

Phone Number: _____ Social Security Number: _____

Circle One: MALE or FEMALE

Emergency Contact Information:

Name: _____

Home Phone Number: _____ Cell Phone Number: _____

Relationship to Patient: _____

Contact if ever admitted to West Virginia University Hospital or Emergency Department? YES / NO

Insurance Information:

Insurance Holder (Subscriber): _____

Insurance Name: PEIA (If you are the subscriber/Insurance Holder – enter ONLY ID Number below)

Subscriber Birth Date: _____ Subscriber Social Security Number: _____

Subscriber Address, City, State, Zip: _____

Subscriber Phone Number: _____ Subscriber Employer: WVU

ID Number: _____ Group Number: 7770