MONTGOMERY COUNTY
OCCUPATIONAL MEDICAL SERVICES

255 Rockville Pike, Suite 125
Rockville, MD 20850
240-777-5118

INFORMED CONSENT FOR ADMINISTRATION OF INACTIVATED INJECTABLE INFLUENZA VACCINE

The influenza vaccine is administered to prevent the spread of influenza. The vaccine offered is an inactivated (killed) virus which has been available in the United States for many years. It is administered as a shot directly into the muscle. It is approved for healthy adults and children.

The influenza vaccine is developed yearly based on the previous year's strain of influenza, and should be given in October and November so that protection may be afforded through spring.

As with most vaccinations, there may be some associated reactions. There have been infrequent reports of fever, chills, and general flu-like symptoms. Although current influenza vaccines contain only a small quantity of egg protein, on rare occasions, they can induce an allergic response (rash or breathing problems) in egg sensitive people. There has been no recent significant risk of Guillain-Barre syndrome (GBS), a condition that causes paralytic illness (paralysis) from which people usually recover. Centers for Disease Control (CDC) data indicates that any risk of developing GBS from influenza vaccine appears to be far lower than the risks associated with severe influenza among persons for whom the vaccine is recommended. There is some risk, however small, of contracting GBS.

I understand that if I receive the vaccine, there is no guarantee that I will not contract influenza.

I have had it explained to me that there are risks, such as high fever, chills, or general flu-like symptoms which may occur as a result of the vaccination. I have completed the Influenza Medical History Form on the reverse side of this form.

I have read or have had explained to me the information in the Vaccine Information Statement (VIS) about the vaccine.

I further indicate that I am not allergic to eggs.

I certify that this vaccine is administered at my request, and hereby release the County from any and all liability for any effect or side effects of the administration of the influenza vaccine.

I, the undersigned, an employee of Montgomery County Government, hereby authorize Occupational Medical Services to administer the influenza 2017-2018 vaccine to me.

The following contact information is recommended by the CDC (Center of Disease Control) in the case of an adverse reaction, emergency, or warnings issued by the CDC about the disease or vaccine.

Please write legibly

NAME (Print):_____ **SS#:**_____ **AGE:** _____

DEPT: _____ **JOB TITLE:** _____

SIGNATURE: _____ **DATE:** _____

HOME ADDRESS: _____ **HOME PHONE:** _____

_____

Route of Administration: **Intramuscular** **Site of Injection:** **Deltoid** ☐ **Left** ☐ **Right**

Manufacturer: _____ **Lot #:** _____ **Expiration Date:** _____ **Dose:** **0.5cc**

Signature and title of Nurse reviewing medical history and administering vaccine: _____ **Date:** _____

Medical History for Influenza Vaccine

Be sure to answer <u>all</u> questions

1. Have you ever received the flu vaccine? ☐ Yes ☐ No

2. Have you ever had an allergic reaction (hives, shortness of breath, high fever or seizures) to the flu vaccine? If yes, when _____ ☐ Yes ☐ No

3. In the past have you ever had an allergic reaction to **any** vaccine? ☐ Yes ☐ No

4. Are you allergic to eggs or Thimerosal (a preservative in medicines)? ☐ Yes ☐ No

5. Are you sick today? ☐ Yes ☐ No

6. Do you have any cold or flu like symptoms today? ☐ Yes ☐ No

7. Are you pregnant? ☐ Yes ☐ No

8. Do you have a weakened immune system or do you take any medications which weaken the immune system (steroids, cancer drugs or drugs for HIV/AIDS)? ☐ Yes ☐ No

9. Have you ever been diagnosed with Guillian-Barre Syndrome (a type of paralysis)? ☐ Yes ☐ No

10. Please check if you have any of the following health conditions:

☐ Heart Disease ☐ Lung Disease ☐ Metabolic Disease such as Diabetes

☐ Asthma ☐ Kidney Disease ☐ Anemia or other blood disorders