VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu.**

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. Women who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/flu**.

Consent for Influenza Vaccine -Child

Child's name (Print):	Birthdate:
Address:	
Parent's name:	Day Phone:

1. I have read the Vaccine Information Sheet and have had my questions answered.
2. I understand the risks and benefits of the vaccination, however, with all vaccines there is not guarantee that my child will become immune or that my child will not experience side effects.
3. I authorize Platte Health Center to release medical information necessary to determine benefits payable for this service. I understand that I am financially responsible for services regardless of insurance coverage.
4. **Medical information:**

yes	no	
		Has child ever received an influenza vaccination (including intranasal)?
		Has child ever had a serious medical or allergic reaction to influenza vaccination (including intranasal)?
		Is child sick today (running fever over 100)?
		Is the child currently COVID-19 positive?
		Is the child allergic to any component of the vaccine?
		Does the child have a history of Guillain Barre Syndrome within 6 weeks of receiving the influenza vaccine?

___Yes, I hereby give my consent for the child named above to receive the influenza vaccination.

_____ _____
Parent Signature Date

Insurance information: Parent must complete this section.

1. Does the child have Medicaid insurance? Yes No (If yes, you do not need to complete questions 2-3)
2. Is your child Alaskan Native or American Indian? Yes No (If yes, you do not need to complete question 3)
3. Does the child have Health Insurance? Yes No (If Yes complete information below)

____My Health Insurance does not pay for Influenza vaccination

Insurance i.e. Avera, Wellmark, Dakotacare, etc	Policy Number	Subscriber	Group Number

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The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota, SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information in accordance with applicable HIPAA Privacy Act standards and requirements. Immunization records remain confidential, and any person who fails to protect the information is guilty of a class 1 misdemeanor. If you choose NOT to have you/your child's immunization record shared with other providers, you may request a refusal form.

For office use only:

_____ _____
Signature of staff administering Date

Site Given: __Left __Rt __deltoid __thigh
Manufacturer:
Lot Number:
Expiration date:

Consent for Influenza Vaccine -Adult

Name (Print):	Birthdate:
Address:	
Are you an employee of Platte Health Center? Yes No	Day Phone:

Medical information:

yes	no	
		Have you ever received an influenza vaccination (including intranasal)?
		Have you ever had a serious medical or allergic reaction to influenza vaccination (including intranasal)?
		Are you sick today (running fever over 100)?
		Do you currently have COVID-19?
		Are you allergic to any component of the vaccine?
		Do you have a history of Guillain Barre Syndrome within 6 weeks of receiving the influenza vaccine?
		Are you at least 18 years old?

I consent to receive the influenza vaccine. I have received and read the Influenza Vaccine Information Sheet. I have been provided an opportunity to ask questions about the disease and the treatment. I understand the risks and benefits of the vaccination, however, with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I hereby request the influenza vaccine.

Patient Signature _____ Date _____

Insurance information

Insurance i.e. Avera, Wellmark, Dakotacare, etc	Policy Number	Subscriber	Group Number

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For office use only:

Signature of staff administering _____ Date _____

Site Given: __Left __Rt __deltoid __thigh
Manufacturer:
Lot Number:
Expiration date: