MICHIGAN ME	DICINE	MRN:	FOR OFFICE			
		NAME:	USE ONLY			
Consent - Inactivated Influ	uenza Immunization	BIRTHDATE:				
		CSN:				
Date:// (mm/dd/	уууу)					
Please mark one:						
Registered Patient in the University of Michigan Hospital Health System (UMHS)						
Medical Record Number (MRN):						
			//			
First Name	Last Name		Birthdate (mm/dd/yyyy)			

First Name	Last Name	// Birthdate (mm/dd/yyyy)
Non-UMHS patient:		
First Name	Last Name	// Birthdate (mm/dd/yyyy)

What is the flu? Influenza or the flu is a serious illness caused by viruses that infect the nose, throat, and lungs. Influenza can cause fever, chills, headache, dry cough, sore throat, and muscle aches. The illness usually lasts only a few days. Most people who become infected recover completely. Flu-related complications (including pneumonia and possibly death) are more likely to occur in the elderly and in people with chronic health problems.

What is the flu Immunization? Inactivated (killed) influenza immunization, given as a shot, has been used in the United States for many years. The immunization is updated every year because the viruses change. Protection develops about two weeks after getting the shot and protection may last up to one year. Some people who get the flu vaccine may still get the flu, but they will usually get a milder case than those who did not get the shot. The flu vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

What are the side effects? Serious side effects from the flu immunization are very rare. The viruses in the inactivated influenza immunization have been inactivated or killed. You cannot get influenza from the immunization. Mild side effects that can occur are soreness, redness, or swelling where the shot was given, fever, and/or aches. If these problems occur, they usually begin soon after the immunization and last 1-2 days. A severe allergic reaction is rare, but possible. If an allergic reaction does occur, it is within a few minutes to a few hours after the shot. For first time participants, we recommend you stay for observation 5 minutes after your immunization. Guillain-Barré syndrome (GBS), is an illness characterized by fever, nerve damage, and muscle weakness. In 1976,

vaccination with the swine flu vaccine was associated with getting GBS. Several studies have been done to evaluate if other flu vaccines since 1976 were associated with GBS. Only one of the studies showed an association. That study suggested that one person out of 1 million vaccinated persons may be at risk of GBS associated with the vaccine.

I have been given a copy of

from the Centers

for Disease Control and Prevention. I have been given a chance to ask questions about the immunization and this form and my questions have been answered. I understand the possible benefits and risks of the vaccination. I consent to the Inactivated Influenza Vaccine at this time.

## I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM BEFORE I SIGNED IT.

Signature of Patient	or Legally Authoriz	zed Representative (If	patient is a minor o	r unable to sign)	
Printed Name of Leg Relationship:		epresentative (If patien It DNext-of-Kin	t is a minor or unab ☐ Legal Guardia		
Consent Obtained, I	Explained and Witr	nessed by (Name)	Signature	// Date(mm/dd/yyyy)	A.M./ P.M. <b>Time</b>
Content sour	rce: Centers for Dise	ease Control and Preve	ntion, National Cente	er for Immunization and Respiratory	Diseases (NCIRD) Page 1 of 1
31-10162	VER: A/18 HIM: 06/18	Medical Record		Consent – Procedure / Trea	atment / Evaluation

			MRN: NAME:	FOR OFFICE				
						BIRTHDATE:	USE ONLY	
Immunization Record - Inactivated Influenza Immunization					CSN:			
Date:/_	/	_ (mm/dd/y	ууу)	Ag	ge: _			
Please check	all that apply:							
Ethnic back	Latino							
□ Asian	Indian or Alas can American	ka Native	□ Nativ	ic/Middle Easter e Hawaiian or C e/Caucasian			ler	
Please answe	er the following	g questions	and cheo	ck yes or no:				
1. Do you have an allergy to eggs or other vaccine component?				□ No	□ Yes			
2. Do you currently feel sick or have a fever?				□ No	□Yes			
3. Have you ever had Guillain-Barré syndrome?				🗆 No	□ Yes			
4. Are you allergic to Benadryl® or epinephrine?				🗆 No	□ Yes			
5. Are you allergic to latex?				□ No	□ Yes			
6. Have you ever had a bad reaction to a vaccine?			□ No	□ Yes				
Printed name of	person who com	pleted this for	rm			// Date	(mm/dd/yyyy)	
FOR STAF	F USE ONL	<b>Y</b> (Immun	ization a	administration	info	ormation)		
Above answer	s reviewed with	patient.						
Vaccination Inf	formation State	ment (VIS) gi	iven to pat	ient:				
Vaccination ac		Dos	e: 0.5 cc	Site: Delto	id (ci	ircle one): L	R Route: IM	
Vaccine Admir	nistered by (Nan	ne)	Sig	gnature		/// Date (mm/dd/yyy	A.M./ P.M. y) <b>Time</b>	
Content so	ource: Centers for D	isease Control a	and Preventio	on, National Center for	r Immi	unization and Respi	ratory Diseases (NCIRD) Page 1 of	
86-10000	VER: A/18 HIM: 07/18	Medical R	ecord			Immunization Record		