

THE BOLLES SCHOOL INFLUENZA VACCINE CONSENT FORM

Student Name: _____

(Please print)

Address: _____

Influenza is a viral respiratory illness with symptoms which range from mild to serious and potentially fatal. There is no cure for influenza. The disease is contracted by respiratory spread from infected individuals. Complications of Influenza include muscle/joint pain, sore throat, headache, nausea, diarrhea, cough, pneumonia, paralysis and suffocation. Immunization against Influenza can prevent infection and thus prevent these complications.

The vaccine against Influenza, prepared from eggs, is free of association with human blood or blood products. Research has shown that persons who develop antibodies against Influenza Virus are protected against the disease. Influenza Vaccination induces protective levels of antibodies in greater than 90% of healthy adults and teenagers who receive the Vaccine. Influenza Virus mutates yearly, thus yearly Vaccination is recommended to maintain immunity.

POSSIBLE SIDE EFFECTS:

The possible side effects of the Influenza Vaccine may include:

- | | | |
|--------------------|--------------------------------------|--------------------------------|
| 1. Malaise/Fatigue | 4. Injection Site Infection/Swelling | 7. Upper Respiratory Infection |
| 2. Headache/Nausea | 5. Dizziness | 8. Rash |
| 3. Low Grade Fever | 6. Muscle/Joint Pain | |

The incidence of these complications is low and generally limited to the first few days after the Vaccination.

CONTRAINDICATION:

Persons should not receive the Influenza Vaccine if they have any of the following:

- Allergy to eggs, chicken feathers or Thimerosal (mercury derivative) or any component of the Vaccine.
- Any serious active infection, severe heart or kidney disease.
- Currently pregnant or nursing.
- History of Guillain-Barre Syndrome.

CONSENT:

- I have been given information about Influenza and the Influenza Vaccine. I have had the opportunity to ask questions, and I understand the benefits of Influenza Vaccination.*
- I understand that my student must receive the Vaccination yearly to maintain immunity. I understand that the effectiveness of the Vaccine is reduced if my student does not receive yearly Vaccinations. I understand the Influenza Vaccine will not prevent other bacteria or viruses that infect the lungs or respiratory system.*
- I understand that, as with all medical procedures, there is no guarantee of success, or that my student will not experience an adverse side effect from the procedure. Further, I am willing to accept the risks for my student. I have been instructed to contact my family physician or the Emergency Room if my student experiences adverse effects which may be associated with the Vaccine.*

- 4)
- | | | |
|------------|-----------|---|
| <i>Yes</i> | <i>No</i> | <i>Please respond "yes" or "no" to the following:</i> |
| ___ | ___ | <i>1. Allergy to eggs, chicken feathers, or Thimerosal.</i> |
| ___ | ___ | <i>2. Measles immunization within the last 30 days.</i> |
| ___ | ___ | <i>3. Have a cold or fever at present.</i> |
| ___ | ___ | <i>4. Pregnant or nursing.</i> |
| ___ | ___ | <i>5. Allergy to gentamicin sulfate.</i> |
| ___ | ___ | <i>6. History of Guillain-Barre Syndrome.</i> |

- 5) *I hereby give consent for my student _____ to receive the Flu vaccine.*
Student Name (Please Print)

Parent Signature _____ *Parent Name* _____
(Please Print)

Patient/Student Signature _____ *Date* _____