INFLUENZA IMMUNIZATION INFORMED CONSENT

Influenza is a contagious respiratory illness caused by flu viruses. The illness can be mild to severe, and at times can lead to death. This acute disease comes on suddenly, with self-limiting symptoms (resembling a severe "common cold") within 2-7 days of onset.

HIGH RISK FOR COMPLICATIONS FROM INFLUENZA

- **Children: < 5 years / increases for < 2 years**
- **Pregnant women**
- **Care Center residents**
- **Adults: 65 or older**
- **American Indian and Alaskan Native populations**

Chronic Medical Conditions:

- **Respiratory:** Asthma, COPD, Cystic Fibrosis
- **Cardiac:** Congenital Heart Disease, CHF, Coronary Artery Disease
- **Endocrine:** Diabetes, Morbidly Obese
- **Renal:** Kidney Failure
- **Liver Disorders**
- **Metabolic:** Inherited and Mitochondrial
- **Blood:** Sickle Cell Disease
- **Weakened Immune:** HIV, AIDS, Cancer, Chronic Steroid Usage, Organ Transplant

CLINICAL INFLUENZA SYMPTOMS

- Chills/Fever
- Muscle or body aches
- Headache
- Fatigue (tiredness)
- Cough
- Sore throat
- Runny or stuffy nose
- N/V (children)

POSSIBLE VACCINE SIDE EFFECTS

Mild: Usually short term, 1-2 days

- Soreness, redness, or edema at injection site
- Hoarseness, sore, red or itchy eyes; cough
- Fever • Aches • Headache • Itching • Fatigue

Severe: Allergic reaction is possible, but very rare

VACCINE INFORMATION STATEMENT (VIS) PROVIDED TO RESIDENT

❑ **Inactivated Influenza VIS Edition Date:**_____/_____/_____ (Statement: www.cdc.gov/flu)

❑ I have received the information about Influenza disease, and have been educated on the benefits and risks associated with the Influenza Vaccine. I hereby give permission and request the Flu Vaccine be administered to me or the person named for whom I am authorized to sign.

_____ _____/_____/_____
Resident/Legal Representative Date Signed

_____ _____/_____/_____
Witness Signature/Title Date Signed

REASON FOR VACCINE DECLINE (Medical or Personal Reasons)

❑ I have received the information about Influenza disease, and have been educated on the benefits and risks associated with the Influenza Vaccine. I hereby **decline** my permission to receive the Influenza Vaccine for the following reason(s):_____

A. Medication Contraindication(s): Check all that apply (Physician needs to be informed of Medical Conditions)

❑ Allergy to eggs or egg products
❑ Previous Hx of severe reaction to Influenza Vaccine
❑ Allergy to Thimerisol (preservative in vaccines) or any vaccine component
❑ History of Guillain-Barre Syndrome (within 6 weeks after previous vaccine)
❑ Febrile Illness at this time (Temp > 101.5° F or 38.6° C)
❑ Other medical conditions (specify)_____

B. Personal Reason(s): Check all that apply (Physician needs to be informed of Personal Reason)

❑ Perceived vaccine ineffectiveness
❑ Fear of needles/injections
❑ Perceived vaccine will "give me the flu"
❑ Fear of side effects
❑ Other personal reasons (specify)_____

_____ _____/_____/_____
Resident/Legal Representative Date Signed

_____ _____/_____/_____
Witness Signature/Title Date Signed

NAME–Last	First	Middle	MR #

PNEUMOCOCCAL IMMUNIZATION INFORMED CONSENT

Pneumococcal disease is an infection caused by a type of bacteria called *Streptococcus pneumoniae* (pneumococcus). There are different types of pneumococcal disease, such as pneumococcal pneumonia, bacteremia, and meningitis.

CLINICAL SYMPTOMS

The symptoms of pneumococcal pneumonia include fever, cough, shortness of breath, and chest pain. The symptoms of pneumococcal meningitis include stiff neck, fever, mental confusion, disorientation, and visual sensitivity to light (photophobia). The symptoms of pneumococcal bacteremia (a bloodstream infection) may be similar to some of the symptoms of pneumonia and meningitis, along with joint pain and chills.

POPULATION THAT SHOULD RECEIVE PNEUMOCOCCAL VACCINE

- All adults 65 years of age and older • Residents in Care Centers • (Ages 19-64) smoker or has asthma
- (Age 2-64) Long term health problem such as heart disease, lung disease, sickle cell disease, diabetes, alcoholism, cirrhosis, leaks of cerebrospinal fluid or cochlear implant. (Consult physician for dose regimen.)
- (Age 2-64) Condition that lowers the body's resistance to infection, such as: Hodgkin's disease, lymphoma or leukemia; kidney failure; multiple myeloma; nephrotic syndrome; HIV infection or AIDS; damaged spleen, or no spleen; organ transplant. (Consult physician for specific dose regimen.)
- (Age 2-64) Drug treatment that lowers the body's resistance to infection, such as: long-term steroids, certain cancer drugs, radiation therapy. (Consult physician for dose regimen.)
- Second dose is recommended for residents 65 years or older, that received first dose prior to age 65. If second dose is given, it should be given 5 years after initial dose. (Consult with physician.)

CLINICAL SIDE EFFECTS OF PNEUMOCOCCAL VACCINE

• Redness or pain at injection site • Fever, muscle aches, rash • Severe reaction is rare

VACCINE INFORMATION STATEMENT (VIS) PROVIDED TO RESIDENT

❑ **Pneumococcal Polysaccharide Vaccine (VIS) Edition Date:**_____/_____/_____ (VIS: www.cdc.gov/vaccines)

❑ I have received the information regarding Pneumococcal Infections, and have been educated on the benefits and risks associated with the Pneumococcal Polysaccharide Vaccine (PPSV). I hereby give permission and request the Pneumococcal Vaccine be administered to me or the person named for whom I am authorized to sign.

_____ _____/_____/_____
Resident/Legal Representative Date Signed

_____ _____/_____/_____
Witness Signature/Title Date Signed

❑ I have received the information on Pneumococcal Infections, and have been educated on the benefits and risks associated with the Pneumococcal Polysaccharide Vaccine (PPSV). I hereby **decline** my permission to receive the Pneumococcal Vaccine for the following reason(s):

A. Medical Contraindication: Check all that apply
(Physician needs to be informed of medical condition)
- ❑ Previous Hx of severe reaction to PPSV
- ❑ Febrile illness at this time (Temp 101.5° or 38.6°C)
- ❑ Other Medical Conditions (specify _____

_____

B. Personal Reason(s): Check all that apply
(Physician needs to be informed of personal reason)
- ❑ Perceived vaccine "ineffectiveness"
- ❑ Fear of needles/injections ❑ Fear of side effects
- ❑ Other Personal Reasons (specify)_____

_____

_____ _____/_____/_____
Resident/Legal Representative Date Signed

_____ _____/_____/_____
Witness Signature/Title Date Signed

NAME–Last First Middle MR #