Updated AUGUST 2016

INFLUENZA (INACTIVATED) IMMUNIZATION CONSENT AND RELEASE FORM

First Name: ______________________________ Middle Initial: ______ Last Name: __________________________________
Address: _____________________________________ City: ___________________________ State: ______ Zip: _________
Phone: (_____)________________ Emergency Contact: ___________________________ Phone: (_____)_______________
Birth date: _____/_____/_____ Age: ______ Sex: M F Primary Care Physician: ______________________________

1. The Disease. The influenza vaccine is recommended for individuals who wish to reduce their chances of becoming infected with influenza. Influenza (flu) is caused by viruses. When people get the flu, they may have fever, chills, cough, sore throat, headache, muscle aches, runny or stuffy nose, and fatigue. Illness may last several days or a week or more, and complete recovery is usual. However, complications may lead to pneumonia or death in some people. For the elderly, young children, and people with weakened immune systems, flu may be especially serious.

The influenza vaccine is available in two types: a live, attenuated vaccine, which is sprayed into the nostrils, and an inactivated vaccine, which is given by injection with a needle. The inactivated flu vaccine is highly recommended for the following high risk individuals:

* Persons over the age of 50

* Children 6 months of age and older

* Pregnant women

* Persons with heart, lung, or kidney disease or a weakened immune system

2. The Vaccine. Today's flu vaccines cause fewer side effects than those used in the past. In contrast with some other vaccines, flu vaccine can be taken safely during pregnancy; however, flu vaccine should be given to pregnant women according to the chronic illness criteria applied to other persons. One shot will protect most people from influenza during the next flu season.

3. Possible Vaccine Side Effects. Most people will have no side effects from the vaccine. However, tenderness at the site of the shot may occur and last for 1-2 days. Some people will also experience hoarseness; sore, red, or itchy eyes; cough; fever; aches; headache; itching; or fatigue within the first 48 hours. Young children who get inactivated flu vaccine and pneumococcal vaccine (PCV 13) at the same time appear to be at increased risk for seizures caused by fever. Ask your doctor for more information. Also consult your doctor if a child who is getting the flu vaccine has ever had a seizure.

As with any vaccine or drug, the possibility of severe or potentially fatal reactions exists. However, flu vaccine has rarely been associated with severe or fatal reactions. In 1976, an uncommon illness characterized by ascending paralysis (Guillain-Barré Syndrome, or GBS) has been reported following other flu vaccines. Since then, flu vaccines have not been clearly linked to GBS: however, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million. In comparison to the risk of influenza and its complications, the risk of GBS is much lower, and this factor should be considered when deciding whether to receive the flu vaccine.

WARNING:

The following individuals should check with their primary care physician before receiving the influenza vaccine:

* Persons with severe allergies, including a severe allergy to eggs.

* Anyone who has had an allergic reaction to the flu or other vaccine.

* Anyone who has ever had Guillain-Barré Syndrome.

* Persons who are moderately or severely ill.

If you have any questions about influenza or influenza vaccine, please ask now or call your doctor before requesting the influenza vaccine.

I acknowledge that I am voluntarily and knowingly requesting an influenza vaccination from a pharmacist employed by Southeastern Grocers (BI-LO, Harveys, or Winn-Dixie).

I agree to contact my primary care doctor or my pharmacist if I have any concerns or an adverse reaction to the flu vaccination. If I am receiving a flu vaccination for the first time, I agree to remain at the pharmacy for at least 15 minutes after receiving my vaccination in order to be monitored. Should I experience any of the following shortly after receiving the flu vaccination: difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness, I will immediately report back to the pharmacy for follow-up.

I acknowledge receiving a copy of the Vaccine Information Statement that contains information about the influenza vaccine,

flu vaccination: difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat, or dizziness, I will immediately report back to the pharmacy for follow-up.

I acknowledge receiving a copy of the Vaccine Information Statement that contains information about the influenza vaccine, including information on certain adverse reactions that I may experience as a result of receiving the Vaccine. I have read and understand the Vaccine Information Statement and this form about influenza and the influenza vaccine, and I have had the chance to ask questions about the contents of the Vaccine Information Statement and this form. I understand and agree that this company may be required by applicable law may require reporting of certain information without notice to me about my vaccination to the appropriate state and federal regulatory authorities for purposes such as reporting of adverse events or immunization registries.

I understand and have considered the benefits and risks of the influenza vaccine, and I believe that benefits of receiving the influenza vaccine outweigh the risks associated with receiving the influenza vaccine. I hereby consent to have the influenza vaccine administered to me by the company pharmacist.

I further agree to hold harmless this company and its subsidiaries, officers, employees, agents, representatives, contractors, successors and assignees from any claim or action arising out of or, in any way incidental to this vaccination. I am 18 years or older, under no duress, and have read and understood this informed consent for influenza virus vaccination. I will communicate the information provided to me today about my vaccination to my primary care provider, if I have one.

By signing below, I certify that the following statements are true:

- I am the patient or the patient's guardian/personal representative signing on behalf of the patient.
- I read, understand and agree to all the statements on this form.

– I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Southeastern Grocers. I authorize any holder of medical or other information about me to release to CMMS & it's agent any information needed to determine these benefits for related services.

________________________________ ______________________________________

Print Name Signature of Patient or Legal Guardian

Date signed _______________

Pharmacy Use Only:

1. Had flu vaccine before? Y___N___ (If no, patient must wait at least 15 minutes after immunization)
2. Have you ever fainted or felt dizzy after receiving a vaccine? ? Y___N___
3. Prior allergic reaction to flu/other vaccine? Y___N___
4. Have you ever had a seizure disorder for which you are on medication, a brain disorder ,Guillain Barre' Syndrome or other nervous system disorder? ? Y___N___
5. Bleeding disorder? Y___N___
6. Currently sick/fever? Y___N___ , If yes,
   - Do you have a cough? Y___N___
   - Do you have diarrhea? Y___N___
   - Have you been vomiting? ? Y___N___

Place Pharmacy Label Here

7. Thimerosal/mercury allergy? Y___N___
8. Prior allergic reaction to chicken eggs or egg product? Y___N___
9. Prior allergic reaction to any medications? Y___N___
10. Have you received a vaccine in the last 14 days? Y___N___
11. Prior allergic reaction to latex? Y___N___
12. Are you pregnant? Y___N___
13. Do you have a weakened immune system because of HIV/AIDS or another disease, long term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs? Y___N___
14. Do you have long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g.,diabetes) or anemia or another blood disorder? Y___N___

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Date of last physical exam _______________

Date of last physical exam _______________

Vaccine/Manufacturer__________________________

Lot #___________ Exp. Date________

Left arm________ Right arm_________

Date of VIS: ___________________

____ ____________________

Signature of pharmacist administering vaccination Date given

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