

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.imzimize.org/vs
Hoja de información sobre vacunas contra
diferentes tipos de gripe en español. Véase
aquí: www.imzimize.org/vs

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and it spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of the vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).**

Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.

- **If you are not feeling well.**

It is usually okay to get the vaccine when you have a mild illness, but you might be asked to come back when you feel better.

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- 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. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death. The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does 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.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- 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

Vaccine Information Statement

Inactivated Influenza Vaccine

08/07/2015

42 U.S.C. § 300aa-26



Office Use Only

2018 Vaccine Consent Form

School Name: _____

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - Please print using ink (Incomplete forms will not be accepted)

FIRST NAME of Student:		LAST NAME of Student:	
Gender: Male Female	Birthdate: (mo,day,yr)	Age	Homeroom Teacher / Grade
Address		Home Phone # () -	Cell Phone # () -
City	Zip Code	State	Student Race: (Circle one) African American / Black White Alaskan/ Native American Asian Hawaiian / Pacific Islander Other Ethnicity: Non-Hispanic or Hispanic

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential. Please fill out the following questions pertaining to your child's Health Insurance:

Parent / Guardian Information		
First Name	Last Name	Relationship to Patient

REQUIRED INSURANCE INFORMATION (MUST CHECK AN APPROPRIATE BOX)

MEDICAID & MANAGED CARE ORGANIZATIONS

BUCKEYE	CARE SOURCE	MOLINA	PARAMOUNT ADVANTAGE	UHC COMMUNITY PLAN	STRAIGHT MEDICAID	OTHER: (PLEASE SPECIFY NAME)

MEMBER ID#	CASE #

MMIS# (PATIENT'S MEDICAID #) <small>NOTE: THIS IS THE ONLY # REQUIRED FOR BUCKEYE PATIENTS</small>	CURRENTLY HAVE NO INSURANCE <small>*NOTE: IT IS FRAUDULENT TO CLAIM UNINSURED IF YOU HAVE INSURANCE</small>

PRIVATE INSURANCE COMPANIES

AETNA	BCBS	CIGNA	CORE SOURCE	HUMANA	MEDICAL MUTUAL	TRI-CARE	UHC	OTHER: (PLEASE SPECIFY NAME)

CARDHOLDER'S FIRST NAME	CARDHOLDER'S LAST NAME	CARDHOLDER'S DATE OF BIRTH
		MM / DD / YYYY

IDENTIFICATION# / MEMBER ID# / ENROLLEE ID# <small>(INCLUDE ALPHA PREFIX, IF SHOWN ON CARD)</small>	PAYER ID# <small>(IF NOTED ON CARD)</small>


VACCINATION & HEALTH-RELATED QUESTIONS

1	Has your child ever had a life threatening reaction(s) to the flu vaccine in the past?	YES	NO
2	Has your child ever had Guillain-Barre' syndrome?	YES	NO
3	Does your child have an allergy to eggs?	YES	NO
4	Does your child have a blood disorder such as hemophilia?	YES	NO
5	Will this be the first time your child has ever received a flu vaccination?	YES	NO

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 334-738-4840 TO SPEAK TO A REPRESENTATIVE.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected.

Signature of Parent/Guardian _____ Printed Name of Parent/Guardian _____ Date _____

VIS CDC IIV 08/07/2015 LOT Number: _____ RN # _____ Date: _____ AREA FOR OFFICIAL ADMINISTRATION USE ONLY	Health Heroes of Ohio 326 Prairie St. North Union Springs, AL 36089 AL@healthherousa.com 334-738-4840	
---	---	---