



FLU SHOT CONSENT FORM 2019

Informed Consent for Immunization

The 2019/20 influenza vaccines protect against the following viruses:

- an A/Brisbane/02/2018 (H1N1) pdm09-like virus;
- an A/Kansas/14/2017 (H3N2)-like virus;
- a B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage); and
- a B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage) in the quadrivalent vaccines only.

Potential Side Effects:

1. Some people experience redness and tenderness at the injection site for 1-2 days;
2. Less than 10% of those vaccinated can develop flu-like symptoms such as fever, headache, or a mildly upset stomach for a few days;
3. Allergic reactions are rare and usually occur immediately after the injection. They include hive, swelling of the mouth and throat, low blood pressure and difficulty breathing.

Who should not get these vaccines:

1. People with an active neurological disorder;
2. People who are allergic to eggs or eggs products;
3. People who have had a previous allergic reaction to any vaccine;
4. People with a fever or infection at the time of the immunization should wait until their symptoms have abated;
5. People allergic to thimerosal (a preservative found in contact lens solution), gelatine and formaldehyde.

If you develop high fever or unexpected side effects, please see a doctor.

"I have read the above and understand the benefits, risks, and possible complications of receiving the flu shot and will not hold Stein Medical or any representative of Stein Medical who administers the flu shot liable for any adverse reaction that I may suffer"

Company Name	Name of Employee	DOB DD/MM/YR

Care Card Number	Signature of Employee	Date	Stein Medical Witness