

2016-17 Seasonal Influenza Vaccine Consent

What is influenza?

Influenza (commonly known as “the flu”) is a serious respiratory illness that is caused by a virus. People who get influenza may have a fever, chills, cough, runny eyes, stuffy nose, sore throat, headache, muscle aches, extreme weakness and fatigue. The elderly may not have a fever. Children can also have earaches, nausea, vomiting and diarrhea. People of any age can get influenza. Most people recover within a week to ten days and sometimes longer in the elderly and in people with chronic diseases. Most people who get influenza are ill for only a few days, however, the cough and fatigue can persist for several weeks making the return to full activity difficult. Some people can develop complications and may require hospitalization. Influenza spreads by respiratory droplets from infected persons, through coughing or sneezing. It is also spread through direct contact with surfaces contaminated by the influenza virus, such as toys, eating utensils and unwashed hands.

How well does the seasonal influenza vaccine protect against influenza?

For those over 18 years of age the publicly funded influenza vaccine protects against three strains of the virus. For those under 18 years of age, the publicly funded influenza vaccine protects against four strains of the virus. When there is a good match between the influenza strains in the vaccine and the influenza strains circulating in the community, the vaccine can prevent influenza illness in about 60% to 80% of healthy children and adults. Studies have shown that influenza immunization decreases the incidence of pneumonia, hospital admission and death in the elderly. It takes about two weeks after the immunization to develop protection against influenza; protection may last up to one year. People who receive the vaccine can still get influenza, but if they do, it is usually milder. The vaccine will not protect against colds and other respiratory illnesses that may be mistaken for influenza, but are not caused by the influenza virus.

Can the vaccine cause influenza?

No, you cannot get the flu from the vaccine. Vaccination is the most effective way to prevent influenza.

Who can get the seasonal influenza vaccine?

Anyone aged 6 months and older who lives, works or attends school in Ontario is eligible to receive the publicly funded vaccine free of charge.

How many doses of the seasonal influenza vaccine are needed?

Because the influenza virus changes often, it is necessary to get an influenza immunization every year. Children previously immunized with seasonal flu vaccine and adults should receive one dose of the vaccine every year. Children less than 9 years of age receiving the vaccine for the first time require two doses of vaccine at least four weeks apart.

Who should not get the seasonal influenza vaccine?

The following persons should not get the influenza vaccine:

- Infants under 6 months of age
- Anyone who has had a serious allergic reaction (anaphylactic) to a previous dose of vaccine or to any of the vaccine components. However, those with a severe allergy to egg or egg products may still receive the vaccine as recommended by National Advisory Committee on Immunization (NACI). A serious allergic reaction usually means that the person develops hives, swelling of the mouth and throat or has trouble breathing and experiences a sudden drop in blood pressure.
- Anyone who has previously developed Guillain-Barré Syndrome (GBS) within the first 6 weeks following an influenza immunization should avoid influenza immunization at this time.

What are the risks from seasonal influenza vaccine?

Most people who get the vaccine have either no side effects or mild side effects such as soreness, redness or swelling at the injection site. Life-threatening allergic reactions are very rare. If they do occur, it is within a few minutes to a few hours after receiving the vaccine. If this type of reaction occurs medical attention should be sought immediately.

Guillain-Barré Syndrome (or GBS): GBS is a very uncommon disease that causes muscle paralysis and has been associated with certain infectious diseases. Overall, the risk of GBS occurring in association with immunization is small.

Oculo-Respiratory Syndrome (ORS): During the 2000-2001 influenza season, ORS was reported after the influenza vaccine. Since 2000-2001, fewer cases of ORS have been reported. Persons who experienced ORS symptoms in the past may be safely re-immunized with influenza vaccine except for those who have experienced ORS with severe lower respiratory symptoms. These individuals should seek advice from their health care provider.

When should I seek medical attention after immunization with the seasonal influenza vaccine?

You should seek medical attention if you believe that you or someone in your care has had a reaction to a vaccine.

Any reaction to a vaccine should be reported to your health care provider who will report these occurrences to Public Health.

Who should I talk to if I have any questions about seasonal influenza or any other vaccines?

- ✓ Call 1-877-844-1944 (TTY#1-800-387-5559)
- ✓ Visit website www.ontario.ca/flu
- ✓ If you have questions about the vaccine that are specific to your medical condition, you should ask your health care provider
- ✓ Call Peterborough Public Health at 705-743-1000.

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(Please Print Clearly with BLACK INK)



CONFIDENTIAL WHEN COMPLETED

Last Name:		First Name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: / /		Age:
Address:			
City:		Postal Code:	
Phone:		Email (Optional):	
1. Have you received the seasonal flu vaccine in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			
2. Do you have a fever or are you currently feeling unwell? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, describe:			
3. Have you experienced an adverse reaction to previous influenza vaccinations? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, describe:			
4. Are you taking anticoagulants (blood thinners)? <input type="checkbox"/> No <input type="checkbox"/> Yes			
5. Have you ever had Guillain Barré Syndrome (GBS) diagnosed 6 weeks after receiving the influenza vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, do not receive.			
6. Have you ever had Oculo-Respiratory Syndrome (ORS) (cough, wheeze, difficulty breathing, hoarseness, sore throat and/or facial swelling) within 24 hours after receiving the influenza vaccine with severe respiratory symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes –discuss with health care provider			
7. Do you fit into one of these high risk categories for contracting influenza or transmitting influenza? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<ul style="list-style-type: none"><input type="checkbox"/> 65 years old or older<input type="checkbox"/> healthy child 6 to 59 months of age (under 5 years of age)<input type="checkbox"/> health care worker and other care providers in facilities & community settings<input type="checkbox"/> provide essential community services (fire, police, ambulance)<input type="checkbox"/> poultry worker<input type="checkbox"/> members of a household expecting a newborn during the influenza season<input type="checkbox"/> household contact/caregiver to an infant less than 6 months old or to anyone at high risk for influenza related complications<input type="checkbox"/> provide regular child care to children who are between 0 to under 59 months of age<input type="checkbox"/> have a chronic condition (cardiac, kidney, blood or pulmonary etc.)<input type="checkbox"/> resident of a nursing home or chronic care facility<input type="checkbox"/> child or adolescent with a condition treated with acetylsalicylic acid (ASA) (i.e. Aspirin)<input type="checkbox"/> pregnant<input type="checkbox"/> Aboriginal people<input type="checkbox"/> provide services in closed or relatively closed settings (i.e. crew on a ship) to persons in one of the above categories			
8. Are you allergic to the following: Neomycin: <input type="checkbox"/> No <input type="checkbox"/> Yes Formaldehyde: <input type="checkbox"/> No <input type="checkbox"/> Yes Kanamycin: <input type="checkbox"/> No <input type="checkbox"/> Yes Thimerosal: <input type="checkbox"/> No <input type="checkbox"/> Yes			
I confirm that I have read the information on the influenza vaccine and understand the benefits and possible risks of the vaccine. Any questions I had were answered to my satisfaction. I have been advised to wait 15 minutes following vaccination to be observed for potential adverse reactions. I am providing consent for myself (the above-named) to be vaccinated against influenza.			
Signature of client/parent/guardian:		Date: / /	
If signing for someone other than yourself, you must be the appropriate substitute decision maker/legal guardian.			
Name of person completing form if different from above:			
Relationship to above:			
Contact in case of emergency:		Phone:	
Notice of Collection: Personal information is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, to maintain a record of your immunization and to provide statistics required by Peterborough Public Health and the Ministry of Health and Long-Term Care. Should you have questions about the collection and maintenance of this information, please contact Dr. Rosana Salvaterra at 705-743-1000, ext. 264.			
For Vaccinator's Use Only When Electronic Clinic Management Is Not Used			
Are you feeling ill today? fever? infection? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, describe			
Have you ever had a flu shot before? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, describe problems, if any			
Have you ever had an allergic reaction to a vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, describe			
Do you have a blood disorder or are you taking medication that could affect blood clotting? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, describe:			
Did you read the information provided to you? <input type="checkbox"/> No <input type="checkbox"/> Yes		Have you had GBS 6 weeks post immunization? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Vaccine: <input type="checkbox"/> Fluviral® <input type="checkbox"/> Agriflu® <input type="checkbox"/> Influvac® (≥18 years) <input type="checkbox"/> FluLaval Tetra® (<18 years) <input type="checkbox"/> Fluzone Quadrivalent® (<18 years)			
Lot #:	Expiry Date: / /	Date: / /	Time: hrs
Site: <input type="checkbox"/> Deltoid <input type="checkbox"/> Quad <input type="checkbox"/> Right <input type="checkbox"/> Left Dose: 0.5 ml			
Vaccinator Signature:		Designation:	
Panorama Client ID#			
Dose 1: <input type="checkbox"/> Consent Recorded _____ (initials) <input type="checkbox"/> imms recorded _____ (initials) <input type="checkbox"/> Invoiced _____ (initials)			
Notes:			