

**What is the flu?** It is an infection of the nose, throat and lungs caused by the flu virus. It spreads very easily from infected persons through coughing and sneezing or by touching contaminated surfaces such as door knobs and unwashed hands. People who get the flu may have a fever, chills, cough, runny eyes, stuffy nose, sore throat, headache, muscle aches, extreme weakness and fatigue. Symptoms can last five to ten days.

**What is the SINGLE BEST WAY TO PREVENT the flu?**

Get vaccinated each year! It protects against flu viruses that will be most common during the upcoming season. This vaccine cannot give you the flu.

**Who should get the flu vaccine?** Everyone aged 6 months and older should get vaccinated. It especially important for these individuals to get vaccinated:

- those with chronic medical conditions (heart, lung, diabetes, etc.)
- pregnant women all trimesters
- health care workers and emergency service workers
- children under five years of age and their caregivers
- 65 years and older
- Indigenous peoples

**When should the flu vaccine be given?**

- one dose every year
- those under the age of 9 years require 2 doses given 4 weeks apart if they are receiving the vaccine for the first time → after that, only one dose each year

**Are you over 18 years of age?** The injectable vaccine is publicly funded and protects against two strains of 'A' and one strain of 'B' viruses.

**Are you under 2 years of age?** The injectable vaccine is publicly funded and protects against the same 'A' and 'B' viruses as above and an additional 'B' strain as influenza B causes more illness in this age group.

**Are you between 2 years and 18 years of age?** Both the injectable and nasal spray (FluMist) vaccines are publicly funded. They protect against the same 'A' and 'B' viruses as above and an additional 'B' strain as influenza B causes more illness in this age group. Read the FluMist box to see if this live, weakened vaccine is the best option.

**Who should not receive the injectable flu 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 (details→ ask Nurse)
- Tell the nurse if you have had an allergic reaction to any of the following so that you can receive the influenza vaccine that is right for you:
  - ✓ gentamicin (antibiotics)
  - ✓ thimerosal—a form of mercury found in vaccines
- People who are seriously ill with an infection that started recently should wait until they recover before receiving the seasonal influenza vaccine
- People who have had severe oculo-respiratory syndrome (ORS) after a past influenza vaccine that required them to be in the hospital
- people with a history of Guillain-Barré Syndrome (GBS) that developed within 6 weeks of a past influenza vaccine

**FluMist Intranasal Vaccine**

FluMist is **publicly funded for those between 2 years and under 18 years of age**. It is a vaccine that is sprayed directly into the nostrils and allows the body to build protection in a way that is similar to a natural infection with the influenza virus. Both children and adults can shed vaccine viruses after FluMist administration and younger children are more likely to shed the virus from their nose after vaccination than older children and adults. As an additional precaution, people who have been vaccinated with FluMist should avoid contact with severely immunocompromised patients receiving care in hospital in a protected environment (e.g., post bone marrow transplant recipients).

**Who should NOT get the nasal spray (Flumist) vaccine?**

- Those younger than 2 years of age (due to increased risk of wheezing) → they can receive injectable
- People who have had a serious allergy (anaphylaxis) to a previous dose or to any of the vaccine components (i.e. gentamicin, gelatin, arginine, etc.) (details→ask Nurse)
- People with severe asthma (on high dose inhaled or oral steroids or medically attended wheezing in the last 7 days prior to vaccination) or active wheezing
- People under 18 years who are on long-term aspirin or aspirin-containing therapy
- Pregnant or breast feeding women
- People taking a medication to treat influenza (influenza antiviral medication) should be deferred

**Delay the vaccine in those who:**

- have a severe acute illness with or without fever (although it's fine to get the vaccine if the fever is accompanied by minor illnesses like colds)
- are nasally congested and vaccine can't be given → in these cases, the injectable can be given

**Discuss the risks and benefits before getting FluMist in those who have:**

- weakened immune system due to disease or medical treatment
- developed Guillain-Barré Syndrome within 6 weeks of receiving a previous influenza vaccine
- **Side Effects of FluMist?** FluMist is a safe vaccine and most people have no reaction to it. Side effects are generally mild and may last 1 to 3 days. Common side effects include runny nose or nasal congestion, headache, decreased appetite, weakness or fever.

**After the vaccine:** Seek medical attention if you have a concern about a vaccine reaction. The nurse will provide an After-Care Form after the vaccination.

**Questions?**

- ✓ Visit website [www.ontario.ca/flu](http://www.ontario.ca/flu)
- ✓ Your health care provider
- ✓ Call Peterborough Public Health at 705-743-1000 or visit [www.peterboroughpublichealth.ca](http://www.peterboroughpublichealth.ca)

# 2017-2018 Seasonal Influenza Vaccine Consent

(Please Print Clearly with BLACK INK)

**CONFIDENTIAL WHEN COMPLETED**



Last Name:		First Name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Birthdate: year / month / day		Age:
Address:			
City:		Postal Code:	
Contact 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. 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.			
5. 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			
6. 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"> <li>• 65 years old or older</li> <li>• healthy child 6 to 59 months of age (under 5 years of age)</li> <li>• health care worker and other care providers in facilities &amp; community settings</li> <li>• provide essential community services (fire, police, ambulance)</li> <li>• poultry worker</li> <li>• members of a household expecting a newborn during the influenza season</li> <li>• household contact/caregiver to an infant less than 6 months old or to anyone at high risk for influenza related complications</li> <li>• provide regular child care to children who are between 0 to under 59 months of age</li> <li>• have a chronic condition (cardiac, kidney, blood or pulmonary etc.)</li> <li>• resident of a nursing home or chronic care facility</li> <li>• child or adolescent with a condition treated with acetylsalicylic acid (ASA) (i.e. Aspirin)</li> <li>• pregnant</li> <li>• Indigenous people</li> <li>• provide services in closed or relatively closed settings (i.e. crew on a ship) to persons in one of the above categories</li> </ul>			
If you are receiving the injectable vaccine:			
<input type="radio"/> Are you taking anticoagulants (blood thinners)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="radio"/> Are you allergic to: gentamicin: <input type="checkbox"/> No <input type="checkbox"/> Yes thimerosal: <input type="checkbox"/> No <input type="checkbox"/> Yes			
If you are receiving the intranasal vaccine:			
<input type="radio"/> Are you nasally congested? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="radio"/> Are you allergic to: gentamycin: <input type="checkbox"/> No <input type="checkbox"/> Yes gelatin: <input type="checkbox"/> No <input type="checkbox"/> Yes arginine: <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: year / month / day	
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:	
<i>Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, for the purpose of maintaining an immunization record and to provide statistics required by Peterborough Public Health and the Ministry of Health and Long-Term Care. The confidentiality of this information is protected. For more information, please contact our Freedom of Information Coordinator at Peterborough Public Health at 705-743-1000.</i>			

## For Vaccinator's Use

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			
Injectable: 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: Intranasal: Are you nasally congested? <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"/> Influvac® (≥18 years) <input type="checkbox"/> FluLaval Tetra® (<18 years) <input type="checkbox"/> Fluzone Quadrivalent® (<18 years) <input type="checkbox"/> FluMist®			
Lot #:	Expiry Date: year / month / day	Date: year / month / day	Time: hrs
Route: IM <input type="checkbox"/> Deltoid <input type="checkbox"/> Quad <input type="checkbox"/> Right <input type="checkbox"/> Left – Dose 0.5 ml		Route: <input type="checkbox"/> Intranasal → Dose 0.1 ml per nostril → Total 0.2 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:			