

## 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.immunize.org/vis](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

## 1. Why get vaccinated?

**Influenza vaccine** can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

## 2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

## 3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.



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

## 4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

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. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

## 5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do 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. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call **1-800-338-2382** to learn about the program and about filing a claim.

## 7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at [www.fda.gov/vaccines-blood-biologics/vaccines](http://www.fda.gov/vaccines-blood-biologics/vaccines).
- 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](http://www.cdc.gov/flu).

Vaccine Information Statement  
Inactivated Influenza Vaccine

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8/6/2021

OFFICE  
USE  
ONLY



# 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				Phone #				
City		Zip Code		State		Student Race: (Circle applicable) African American / Black White Alaskan/ Native American Asian Hawaiian / Pacific Islander Other Ethnicity: Non-Hispanic or Hispanic		
<b>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:</b>								
Parent / Guardian Information								
First Name				Last Name		Mothers Maiden Name (for state registry)		
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 (MO, DAY, YR)		
						/   /		
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 205-609-0268 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](http://www.immunize.org) or [www.cdc.gov](http://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, Health Heroes of Ohio, 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 08/06/2021  
 LOT Number: \_\_\_\_\_  
 RN # \_\_\_\_\_ Date: \_\_\_\_\_  
**AREA FOR OFFICIAL ADMINISTRATION USE ONLY**

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