Pleasant Health Services, Inc.
20 Long Green Court
Silver Spring, MD 20906
Tel: 301-460-6372, Fax: 301-460-6368

Influenza Vaccination Consent Form

Note: You must read the following information before signing and receiving the flu shot.

Influenza (the flu)

Influenza, also known as the flu, is a contagious disease that is caused by the influenza virus. It attacks the respiratory tract in humans (nose, throat, and lungs). The flu is different from a cold. Influenza usually comes on suddenly and may include these symptoms:

- Fever
- Headache
- Tiredness (can be extreme)
- Dry cough (may last 2 or more weeks)
- Sore throat
- Nasal congestion
- Body aches (may last 3-5 days)

These symptoms are usually referred to as "flu-like symptoms."

Flu Vaccine

Because the flu shot is made from inactivated viruses (the viruses are killed), the vaccine will not give you flu because it is a killed virus vaccine. As with any vaccine, the flu shot may not protect you 100% of all susceptible individuals.

Risks and side effects

Fever, malaise, myalgia, and other systemic symptoms can occur after vaccination. The reactions to the vaccine may be a sore or tender arm at the injection site. These reactions begin 6-12 hours after vaccination and can persist for 1-2 days.

Contraindication

Flu vaccine is highly not recommended for the people who have the followings:

1. People allergic to eggs or eggs products.
2. People sensitive to Thimerosal or Gentamicin.
3. People who have an active neurological disorder.
4. People with a moderate or sever illness and/or with or without fever.

If you have any of the above conditions, please notify your PHS nurse. If you have any questions, please ask now or check with a physician or your health department before receiving the vaccine.
If you experience any significant reactions, see your physician.

I have read the above information about influenza vaccine and I have had the opportunity to ask questions. I also understand the risks and benefits associated with the influenza vaccine and request PHS nurse to administer vaccine to me. **I agree to wait 15-20 minutes after receiving the vaccine.**

Person Receiving Vaccine

Name	Daytime Phone #	Birth date	Age

Street address	City	State	Zip

Signature (Person receiving vaccine)

Date of Vaccination	Manufacturer & Lot No.	☐ Right ☐ Left Site of Injection

Administered By	Date administered