The CDC Vaccine Information Statement is posted on our website and is hanging in our office. Tell us if you want a copy to take home.

WHAT YOU SHOULD KNOW ABOUT THE FLU SHOT

INFLUENZA (FLU) VACCINE

- The influenza vaccine does not cause influenza – you may experience a mild reaction after the shot; however, most people have little or no reaction to flu vaccines.
- Sometimes there is soreness around the injection site for up to 2 days after receiving the vaccine.
- A few people (usually children getting the flu shot for the first time) might get a slight fever, aching, or feel a little sick beginning 6 to 12 hours after vaccination for 1 or 2 days.
- Immediate allergic reactions such as hives, difficulty breathing, and life-threatening shock (Systemic Anaphylaxis) are extremely rare after getting a flu shot. CALL 911.

PRECAUTIONS

- Many flu shots are grown with eggs. If you are allergic to eggs, speak to the doctor, NP or PA first.
- If you have MS (multiple sclerosis) check with your neurologist before getting the shot.
- If you have been allergic to flu shots previously, don't get the shot.

IMPORTANT

- If there is fever under 101 degrees, follow your doctor's directions for fever medication. Drink extra fluids.
- If there is fever over 101 degrees, call our office right away or seek other medical attention.
- Relieve redness and tenderness at injection site by placing a cold washcloth on the area for 15 minutes every two hours.
- If swelling remains after 24 hours, use a warm washcloth on the area for 15 minutes every two hours.
- If you have an egg allergy, talk to the doctor, NP or PA about egg-free options before getting the flu shot.

AUTHORIZATION

I have read the information about influenza and the influenza vaccine, including the CDC vaccine information statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me or to the person named below, for whom I am authorized to make this request.

PATIENT INFORMATION

Print Name_____

Signature _____

Date _____

Age _____ (Required)

Egg allergy __ yes __ no

Office Use

Fluad	65+	Lot _____
Flucelvax	9 - 64	Date _____
Fluarix	6mo - 8	Staff _____
		Acct _____