FREIDERICA
Pharmacy & Compounding

Consent Form: Inactivated Influenza Vaccine 2015-2016

Influenza Infection (flu): The flu is a respiratory infection caused by influenza virus. People with the flu may experience fever, chills, headache, cough, and muscle aches. The flu may last several days or a week or more, and complete recovery is usual. However, complications may lead to severe illness such as pneumonia and potentially death.

Influenza Vaccine: The flu shot is made from parts of the dead virus that is given as an injection into the muscle of the upper arm. For best results, the flu shot is given in October and November of each year but may be given anytime from October to March.

Risks and Possible Side Effects of the Influenza Vaccine: Side effects are generally mild and occur infrequently. These reactions include, but are not limited to, tenderness at the injection site, fever, chills, headache, or muscular aches. These symptoms may last up to 48 hours. Allergic reactions may occur but are very rare.

Student Pharmacists administering immunizations: Student pharmacists allowed to perform immunizations in the State of Arkansas have completed all training to be certified to immunize as a pharmacist/student pharmacist in the state of Arkansas and will only perform immunizations under the supervision of a licensed pharmacist also certified to administer immunizations in the state of Arkansas. Patients will be notified in advance that a student pharmacist will be administering their immunization.

By signing, you contend that you:

- Do not have an allergy to eggs or egg products.
- Do not have an acute illness with fever.
- Have not had nor are at increased risk for having Guillian-Barre Syndrome.
- Have not had a serious reaction to a flu shot.

By signing below, I authorize Freiderica Pharmacy and Compounding to bill my insurance for the above vaccination. I understand that I am responsible for any copays or non-covered claims.

By signing, I signify that I understand the above.

_____ _____ _____
PRINT Name: Last, First Date of Birth Cell Phone #

_____ _____
Address Email Address

_____ _____ _____
City State Zip Code

X_____ _____
Signature Date

_____
Employer

_____ _____ _____
Insurance Carrier ID # Group #

By signing, I signify that I have received HIPAA documents.

X_____ _____
Signature Date

Lot #:_____ Exp Date: _____Immunizer Signature: _____