上海沃德医疗中心
WorldPath Clinic International

INFLUENZA VACCINE - PATIENT INFORMATION
(2014 – 2015)

FLU

Influenza (flu) is a respiratory disease caused by the influenza virus infection. The types or strains of influenza virus that cause illness may change from year to year, or even within the same year. People who get flu may have fever, chills, headache, dry cough, muscle aches and may be sick for several days. Most people recover completely. However, for some people, flu may be especially severe, and pneumonia or other complications may occur.

FLU VACCINE

The regular flu vaccine contains killed influenza virus of the types for 2014/ 2015 recommended by WHO （Northern Hemisphere）and Europe Union. The types of virus included are those that have most recently been causing influenza. The vaccine will *not* give you the flu because it is a **killed virus vaccine.** As with any vaccine, flu vaccine may not protect 100% of all susceptible individuals.

RISKS & POSSIBLE SIDE EFFECTS

Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the local reactions may be redness, indurations and swelling on site of injection, a sore or tender arm where the injection was given, or possibly fever, chills, headache, or muscle aches. These side effects may last 24 to 48 hours. Most people who receive the vaccine either have no reaction or only mild reactions. There is also a possibility, as with any vaccine or drug, that an allergic or other serious reaction or even death could occur. Also, medical events completely unrelated to the vaccine may occur coincidentally following vaccination.

LAST NAME:	**FIRST NAME:**	**DATE OF BIRTH:**
FILE NUMBER:	**PHONE:**	**DATE:**

PLEASE ANSWER THE FOLLOWING QUESTIONS AND CHECK THE APPROPRIATE COLUMN:

	YES	NO
HAVE YOU READ THE INFLUENZA VACCINE INFORMATION STATEMENT ABOVE?		
ARE YOU ALLERGIC TO EGGS or CHICKEN PROTEINS?		
HAVE YOU EVER HAD AN ALLEGIC REACTION TO A PREVIOUS FLU VACCINE?		
ARE YOU ILL WITH A FEVER GREATER THAN 100ºF(37.7ºC)?		
DO YOU HAVE A HISTORY OF GUILLAIN-BARR SYNDROME?		
ARE YOU HAVING IMMUNOSUPPRESSIVE THERAPY e.g. CHEMOTHERAPY FOR CANCER?		
ARE YOU ALLERGIC TO FORMALDEHYDE, NEOMYCIN ,OCTOXINOL 9 OR ANY VACCINE EXCIPIENTS ?		
ARE YOU SUFFERING ACUTE INFECTION?		
ARE YOU PREGNANT OR IN BREASTFEEDING?		

If you have any of the above, please notify the medical staff. 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 and influenza vaccine, and I have had a chance to ask questions. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to:

☐ me or ☐ the person named below for whom I am authorized to sign.

Information – Person to Receive Vaccine	**FOR CLINIC USE ONLY: DOSE**
Name:	**36 mos. & above: 0.5cc ☐ 6mos. to 35 mos : 0.25cc ☐**
Date of Birth:	**Vaccine Brand:**
Age:	**Site of injection:**
Signature:	**Lot No:**
(of patient or parent or guardian)	**Nurse Signature:**