PRINT

2011-2012 UNC Health Care Employee INFLUENZA VACCINE CONSENT FORM

Trivalent Influenza Vaccine (LAIV-Live attenuated vaccine/nasal mist or TIV-Inactive vaccine/injection)

UNC Health Care Occupational Health tele- 966-4480 fax- 966-6326

(PLEASE PRINT CLEARLY)

Employee Name /Department (print clearly)				
#EID or #Medical Record	Birthday (mm/dd/yy)	What is your association to UNC Health Care? Please check all that apply.	☐ Employee ☐ Volunteer ☐ Fellow ☐ Other, specify:	☐ Resident ☐ Board Member

Annual influenza vaccination is the most effective method for preventing influenza virus infections and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccine. Trivalent inactivated influenza vaccine (TIV) can be used for any person including those with high risk conditions. No preference is indicated for LAIV or TIV when considering vaccination of healthy nonpregnant persons aged 2-49 years. Because the safety or effectiveness of LAIV has not been established in persons with underlying medical conditions that confer a higher risk for influenza complications,these persons should be vaccinated only with TIV. The strains for 2011-2012 are; A/California/7/2009 (H1N1)-like virus,A/Perth/16/2009 (H3N2)-like virus, B/Brisbane/60/2008-like virus.

Contraindications for Vaccine (TIV/injection and LAIV/nasal mist)

YES	NO	
☐	☐	1. Are you allergic to eggs or egg products?
☐	☐	2 Have you ever had Guillian-Barre Syndrome within 6 weeks of taking a flu shot?
☐	☐	3. Have you ever had an anaphylactic reaction to an influenza vaccine?

Allergies (check any that apply)-thimerosal-free vaccine is available

☐ Latex ☐ Thimerosal (preservative in contact lens solution) ☐ Neither

Considerations for persons requesting LAIV-live attenuated vaccine/nasal mist (all must be checked "No" to be eligible)

Yes	No	
☐	☐	1. Pregnant
☐	☐	2. Age greater than 49 years (i.e. 50 years or older)
☐	☐	3. Immuno-compromised (within 3 months; oral steroid use, chemotherapy, immune-suppressive medications)
☐	☐	4. HIV infection
☐	☐	5. Asthma
☐	☐	6. Chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurological/neuromuscular, hematologic, or metabolic disorders
☐	☐	7. Works in a Stem Cell Transplant Unit

Signature----------Date----------

Health Care Provider complete this section:

Vaccine:_____**Lot#**_____**Expiration Date:**_____

Site:_____ **Dose: 0.5ml IM Intranasal**

Signature of Health Care Provider_____**Date**_____