FLU VACCINE INFORMATION AND CONSENT LETTER

To: _____

Purpose:

This letter provides important information regarding the seasonal influenza (flu) vaccine. The flu vaccine is recommended annually for all persons aged six months and older to reduce the risk of flu illness, hospitalization, and death. Please read this information carefully before providing your consent.

What is Influenza?

Influenza (flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness, and at times can lead to hospitalization or death. The best way to prevent flu is by getting vaccinated each year.

Benefits of the Vaccine:

The flu vaccine can prevent flu illness, reduce the severity of flu symptoms, and decrease the risk of flu-associated hospitalization and death. It also helps protect people around you, including those who are more vulnerable to serious flu illness.

Risks and Side Effects:

Some people may experience mild side effects such as soreness, redness, or swelling at the injection site, low-grade fever, or aches. Serious side effects are rare but can include severe allergic reactions. Please inform the healthcare provider if you have any history of severe allergies to vaccines or components thereof.

Contraindications and Precautions:

You should not receive the flu vaccine if you have had a severe allergic reaction to a previous flu vaccine or any of its components. Tell your healthcare provider if you have Guillain-Barré Syndrome (GBS), are pregnant, or have any other medical conditions.

Consent to Vaccination:

I acknowledge that I have read or had explained to me the information in this letter regarding the flu vaccine. I have had the opportunity to ask questions and understand the benefits and risks of the vaccine. I consent to receive the influenza vaccine. I understand that no guarantees have been made regarding the vaccine's effectiveness or safety.

Acknowledgment and Signature:

Printed Name of Recipient: _____

Date: _____ Signature of Recipient: _____

Healthcare Provider Administration Record:

Vaccine Manufacturer: _____

Vaccine Lot Number: _____

Date of Vaccination: _____ Site of Injection: _____

Healthcare Provider Name: _____

Healthcare Provider Signature: _____

Your health information is protected under the Health Insurance Portability and Accountability Act (HIPAA). Information about your vaccination may be shared with your healthcare providers, public health agencies, and others as permitted or required by law.

Legal Compliance:

This document and the vaccination it authorizes comply with applicable United States federal and state laws. Any disputes arising under this consent will be governed by the laws of the relevant jurisdiction.

Recipient's Signature	**Healthcare Provider's Signature**
Signature: _____	Signature: _____