San Francisco VA Health Care System

INFLUENZA VACCINE CONSENT FORM 2022 - 2023

Disease: Influenza (flu) is a contagious disease that is caused by the influenza virus. When people get influenza they may have fever, chills, headache, dry cough, and muscle aches. The illness may last several days or longer. Complete recovery is typical. Complications, however, can happen. These include pneumonia and death. For people with heart, lung, or kidney disease, diabetes, and for immune compromised patients, the flu may be especially serious. In addition, elderly patients, young children, and pregnant women (which may include VA patients and our own family members) are also at increased risk of flu complications. Because flu and COVID-19 symptoms can overlap, preventing flu can remove a cause of infection otherwise suspected as COVID-19. By protecting ourselves we also help protect our patients, family, and friends.

Vaccines: For 2022-2032, Quadrivalent (four-component vaccines) vaccines are recommended to contain 4 influenza virus strains (two A subtypes and two B lineage viruses).

Vaccines available at the SFVAHCS for the 2022 – 2023 Flu Season:

AFLURIA QUADRIVALENT (for > 6 months up to 64 years of age) is for active immunization to prevent disease caused by the influenza virus subtypes A and B targeted by the vaccine. AFLURIA QUADRIVALENT is an inactive (non-infectious, killed viruses) and cannot cause influenza. It is egg containing. AFLURIA QUADRIVALENT is intended to provide protection against illness due to influenza viruses only and cannot provide protection against all respiratory illnesses. In adults who received AFLURIA QUADRIVALENT, the most common local side effect was pain (40%). The most common generalized side effects were muscle aches and headache (20%).

FLUAD (for 65 years of age and older, preferred vaccine): FLUAD (Influenza Vaccine, Adjuvanted) is an inactivated (non-infectious, killed virus) and cannot cause influenza. It is egg containing. It is an inactivated, egg-containing quadrivalent vaccine. The most common local side effects observed injection site pain (16.3%), headache (10.8%) and fatigue (10.5%).

Possible Vaccine Limitations: The influenza vaccine will not prevent illness caused by other respiratory viruses, including COVID-19. As with any vaccine or drug, the possibility of severe or potentially fatal reactions exists. An uncommon illness (Guillain-Barré Syndrome) characterized by paralysis and other nerve dysfunction has been reported following other flu vaccines. Allergic reactions (e.g.: egg anaphylaxis) to any vaccine, including its components, can occur.

Maximizing Safety: People with fever should delay vaccination until the fever has resolved for at least 2 days.

I have read the above statement about influenza (flu), potential benefits of flu vaccination, and possible side effects. I have had an opportunity to ask questions and understand the benefits and risks of flu vaccination (Vaccine Information Sheet dated 08/06/2021 provided).

The signature below also acknowledges online access/receipt of the VHA Notice of Privacy Practice, effective 9/20/2019.

______________________	__________	____________	________	________
Name **(Print)**	Job / Title	Unit/Service/Depart	Last 4 of SSN	DOB

______________________________ Signature of Employee

______________ Date

☐ Check if you are a Veteran

Check one: ☐ VA Paid Employee ☐ NCIRE/WOC ☐ Volunteer ☐ UCSF Resident ☐ Student ☐ Other [Specify]__________

Vaccinator Use Only

Manufacturer and Lot Number: ____________________ Date Given: __________ By (initial): ______

Check *only* if indicated: Aged 65 or over → FLUAD adjuvanted vaccine administered ☐

Location: (Circle one) Rt Deltoid Lt Deltoid Other: ________ (Indicate)

Return completed copy to Employee Health BB18 or Mail Stop 11C3

HEALTH CARE PERSONNEL INFLUENZA VACCINATION FORM

I am a VA: ☐ Employee ☐ Volunteer ☐ Other (ex: Trainee, Resident, Intern, Fee Basis, or Researcher)

Please specify: ______________________________

CHECK ONE STATEMENT BELOW AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO SUBMISSION TO EMPLOYEE OCCUPATIONAL HEALTH:

☐ I received the seasonal influenza vaccine this flu season but not administered by VA employee health for example as a VA patient or at an outside site including a drugstore or another provider (I have attached required documentation).

☐ I have been granted a medical exemption from receiving the seasonal influenza vaccine this flu season. I have a contraindication for flu vaccine as defined by CDC. The reasons for contraindication must be recognized contraindications and precautions by the Centers for Disease Control and Prevention, found here: https://www.cdc.gov/flu/prevent/whoshouldvax.htm. This has been discussed and acknowledged by my personal physician. I understand that by declining to receive the vaccine by November 30 or within two weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1192.01, Seasonal Influenza Vaccination Program for VHA Healthcare Personnel.

____
Printed Physician or NP Name and Address

______________________ ________ ______________________
Physician or NP Signature Date National Provider Identification Number

______________________ ________ ______________________
Supervisor Signature Date Supervisor Email

☐ I notified my immediate supervisor in writing that I have a deeply held religious belief that prevents me from receiving the seasonal influenza vaccine this influenza season. I understand that by declining to receive the vaccine by November 30 or within two weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1192.01, Seasonal Influenza Vaccination Program for VHA Healthcare Personnel.

______________________ ________ ______________________
Supervisor Signature Date Supervisor Email

I have read and fully understand the information on this form and have been given the opportunity to have my questions answered. I understand that violation of the directive may result in disciplinary action up to and including removal from federal service.

Name (print): ____________________________ Last 4 SS#:_____________ Dept./Serv ______________________

Employee Signature:____Date:________________________

Employees and volunteers provide this form to the VHA facility Employee Occupational Health Office. Health Professions Trainees provide this form to the Designated Education Officer. Secure electronic submission is permissible.

Return completed copy to vhasfcoccupationalhealthfax@va.gov

8/31/22