FLU CLINIC FOR NEWTOWN SCHOOL AND TOWN EMPLOYEES

(adults only)

October 10th
4 pm - 6 pm
Reed Intermediate School Cafetorium

If you plan to come to this clinic, please complete the attached Consent Form and submit your completed form along with a copy of your insurance card in a sealed envelope to your school office by Oct 6th. This will save time and allow the pharmacy to confirm insurance coverage ahead of time.

Brought to you by Main St. Pharmacy of Danbury and Newtown Health & Wellness

MAIN STREET PHARMACY
CARE & CONVENIENCE YOU DESERVE

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Screening Questionnaire and Consent Form

Patient Information (Patient to complete)

Patient Name: _____ Date of Birth: _____ Age: ___ Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Which vaccine(s) would you like to receive today? _____

Primary Care Physician: _____ Dr. Phone: _____

- ❑ I authorize the pharmacy to send copies of my vaccine documents to my primary care provider

The following questions will help us determine which vaccines may be given today.	**Yes**	**No**	**Don't Know**
Are you sick today?			
Do you have a long-term health problem with heart disease, kidney disease, metabolic disorder (diabetes), anemia or other blood disorders?			
Do you have a long-term health problem with lung disease or asthma? Do you smoke?			
Do you have allergies to medications, food (eggs), latex or any vaccine component (neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, yeast)?			
Have you received a vaccination in the past 4 weeks?			
Have you ever had a serious reaction after receiving a vaccination?			
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder resulting from a vaccine (Guillain-Barre Syndrome)?			
Do you have cancer, leukemia, AIDS or any other immune system problem? Do you have a parent, brother or sister with an immune system problem?			
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?			
During the past year, have you received a transfusion of blood or blood products, including antibodies?			
Are you a parent, family member or caregiver to a newborn infant?			
For women: Are you pregnant or could you become pregnant in the next three months?			
Have you had the following vaccines?			
Pneumococcal Vaccine *you may need 2 different pneumococcal shots*			
Shingles Vaccine			
Whooping Cough (Tdap) Vaccine			

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I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third-party payer as needed and requested payment of authorized benefits to be made on my behalf.

-I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.

-I acknowledge that the pharmacist recommends that vaccinated patients should remain in the waiting area for 15 minutes following administration of the immunization.

-I acknowledge that the administration of an immunization does not substitute for an annual check-up with the patient's primary care physician.

-I certify my receipt of the services covered by this claim. I request the payment be made on my behalf. I authorize the holder to release medical information about me to any party involved in payment or their agents.

-I have read or have had read to me the Vaccination Information Sheet (VIS) or Emergency Use Authorization (EUA) regarding the vaccine(s). I have had the opportunity to ask questions and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Main Street Pharmacy, its affiliates/subsidiaries, officers, directors, and employees from any liability for illness, injury, loss or damage which may result there from.

Patient Signature or legal guardian signature: _____
Today's date (mm/dd/yyyy): _____/_____/_____
If legal guardian print name: _____
_____

PHARMACY USE ONLY

Place RX label here

Lot #_____ Exp date _____
Site (Right / Left arm)

Place RX label here

Lot #_____ Exp date _____
Site (Right / Left arm)

Signature of pharmacist who administered vaccine(s) & provided VIS to patient _____
NPI _____ Date_____
Signature of Certified Immunizing Technician or Intern _____

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/flu**.