INFORMED CONSENT FOR VACCINATIONS

NAME OF RESIDENT: _____

INFLUENZA VIRUS VACCINE

I hereby give the facility permission to administer an Influenza Vaccination annually. I have been instructed that as a result of this vaccination, I may experience some side effects such as: soreness at the injection site, flu-like symptoms, fever, muscle weakness and allergic reactions such as hives, rashes and allergic asthma. Guillain-Barre' is an infrequent, but possible risk of this vaccine. *Please Note: the influenza vaccine may cause an adverse reaction if you are allergic to eggs, egg products, merthiolate (thimersal) or substances containing mercury.*

I understand that I am in a group at high risk of illness or death from influenza and that the most effective means to prevent this disease is the influenza vaccine. Unless my physician feels that it is medically contraindicated, I give my consent to receive the influenza vaccine. I understand that the vaccine is administered annually prior to the influenza season and that I will receive yearly vaccinations unless I withdraw my consent in writing. Further, I understand the risks associated with this vaccine, and will not hold the attending physician, this facility, or its agents responsible for any reactions as a result of the influenza vaccine injection.

_____ _____ ☐ Refused to Sign

Signature of Resident/Authorized Representative Date Reason: _____

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PNEUMOCOCCAL IMMUNIZATION

I hereby give the facility permission to administer the Pneumococcal Vaccination. I have been instructed that as a result of this vaccination, I may experience some side effects such as: redness and pain at the site of injection, fever, muscle aches, and local reactions. In rare circumstances, an allergic reaction, Guillain-Barre' and Guillain-Barre'-like illnesses are a possible risk of vaccination.

I understand that I am in a group at high risk of illness or death from Pneumococcal disease and that the most effective means to prevent this disease is the Pneumococcal vaccine. Unless my physician feels that it is medically unadvisable, I give my consent to receive the Pneumococcal vaccine. I understand that the vaccine is administered only one time, but that there is a possibility that a booster vaccination may be required in about six years. I understand the risks associated with this vaccine, and will not hold the attending physician, this facility, or its agents responsible for any reactions as a result of the Pneumococcal vaccine injection.

_____ _____ ☐ Refused to Sign

Signature of Resident/Authorized Representative Date Reason: _____

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