



# STUDENTS AND STAFF REGISTER NOW!! FOR YOUR INFLUENZA VACCINE

The Student Health & Wellness Services is offering the 2016-2017 **influenza/flu vaccine at a cost of \$15.00**. There will be a limited number of doses available on a first-come, first-served basis.

THE PAYMENT FOR THIS VACCINE IS NON-REFUNDABLE AND NON-TRANSFERABLE.

If you're interested, please complete the form below, and return it along with your payment to the Student Health & Wellness Services (SHWS) mailbox in the Mail Room at SCC or directly to the SHWS building. If your payment is not received along with your form, the reservation for the flu shot will not be made. The vaccine is available now however, we recommend waiting until early October for a longer immunity period. Please call Student Health & Wellness Services for questions. (714) 628-4773.

## P A T I E N T   I N F O R M A T I O N

Influenza (flu) is a respiratory disease caused by influenza viruses. The types or strains of influenza causing illness may change from year to year. People who get the flu may have fever, chills, headache, dry cough, muscle aches, and may be sick several days to a week or more. Most people recover however, for some people, the flu may be especially severe leading to pneumonia or other complications including death.

**The Flu Vaccine** contains killed influenza virus of the types selected by the U.S. Public Health Service and the Center for Biologics Evaluation & Research of the U.S. Food and Drug Administration. The types or strains of virus included are those which have most recently been causing influenza.

**The vaccine will not give you the flu because it is a killed virus vaccine.**

**Risks & Possible Side Effects** Influenza vaccine generally *causes only* mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm at the injection site, or possible fever, chills, headache or muscle aches. These effects may last 24 to 48 hours. Most people who receive the vaccine have no or only mild reactions. There is a possibility, as with any vaccine or drug, that an allergic/other serious reactions, or even death, could occur. Moreover, untoward medical events completely unrelated to vaccine administration may occur coincidentally in the aftermath period following vaccination. *If you experience a reaction, contact your physician or return to SCC Health Services. Unlike the 1976 swine influenza vaccine, flu vaccines used subsequently have not been clearly associated with an increased frequency of Guillain-Barre Syndrome, a neurological disorder which is associated with paralysis.*

**Special Notice** Check with a physician if vaccination is being considered for: 1. Pregnant women; 2. People allergic to eggs, chicken or chicken feathers; 3. People who have an active neurologic disorder; 4. People who have received another type of vaccine during the past 14 days; 5. People with a fever or acute respiratory or other active infections or illnesses. If you have any questions, please ask now or check with a physician or SHWS staff member before receiving the vaccine.

Please make check payable to: RSCCD

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**PLEASE FILL THIS FORM OUT COMPLETELY & ATTACH YOUR PAYMENT ALONG WITH THE FORM**

I have read the above information about influenza vaccine and I have had a chance to ask questions.

I understand the benefits and risks of influenza vaccination and request that the vaccine be given to me or the person below for whom I am authorized to sign.

I HAVE READ AND UNDERSTAND THAT THE PAYMENT FOR THE VACCINE IS NON-REFUNDABLE.

Student Perm # / SS # \_\_\_\_\_  Faculty  Staff Extension # \_\_\_\_\_ Department Name \_\_\_\_\_

### Information – Person to Receive Vaccine

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Signature (Person receiving vaccine or Parent/Guardian) \_\_\_\_\_ Date \_\_\_\_\_

*For Clinic Use:* Date and time of vaccination \_\_\_\_\_

Manufacturer - Sanofi Pasteur Lot #, Expiration \_\_\_\_\_ Deltoid: L. \_\_\_\_\_ R. \_\_\_\_\_

Chronic Disease:  Yes  No Allergies: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_