Fehilys PHARMACY 28 South Main Street, Wexford

Influenza Vaccine Patient Information

What is influenza (flu)?
Influenza is a highly infectious acute respiratory illness caused by the influenza virus. Influenza affects people of all ages. Outbreaks of influenza occur almost every year, usually in winter which is why it is known as seasonal flu.

What is the seasonal flu vaccine?
Each year the seasonal flu vaccine contains three common influenza virus strains. The flu virus changes each year which is why a new flu vaccine has to be given each year. This year's flu vaccine contains the Swine Flu strain.

How does the seasonal flu vaccine work?
Seasonal flu vaccine helps the people's immune system produce antibodies to the flu virus. When someone who has been vaccinated comes in contact with the virus the antibodies attack the virus.

How long does it take the vaccine to work?
The vaccine starts to work in two weeks.

What are the symptoms to look for after influenza vaccination?
The most common side effects and symptoms will be mild.
The main symptoms include:

1. Local skin reactions such as soreness, redness, bruising, swelling and hardening of the skin at the site of the injection may occur.
2. Headache
3. Fever
4. Myalgia (muscle pain)
5. Fatigue (tiredness)
6. Sweating or shivering
7. Arthralgia (joint pain)

Flu like symptoms may occur as your immune system responds to the vaccine but they are not flu and will pass in 24-48 hours.

Rare reactions include:

1. Severe allergic reactions symptoms (including a spreading rash, wheezing, difficulty breathing, swollen face),
2. nerve pains and inflammation,
3. numbness or tingling,
4. fits,
5. blood disorders such as thrombocytopenia,
6. rare nerve disorders and possibly inflammation of the blood vessels.

Seek medical advice if you experience any of these rare symptoms.

Who should get the seasonal flu vaccine?

LAIV (Nasal) is recommended for all children aged 2 to 18 years unless contraindicated.

Inactivated QIV (Injection) is recommended for
1: Those aged 2 to <18 years for whom LAIV is contraindicated
2: Those aged >50 years
3: Those aged 6 months to < 2 years and those aged 18 to <50 years at increased risk of influenza- related complications:
• Those with chronic illness requiring regular medical follow up, e.g. chronic heart disease (including acute coronary syndrome), chronic liver disease, chronic neurological disease (including multiple sclerosis and hereditary and degenerative disorders of the central nervous system), chronic renal failure, chronic respiratory disease (including chronic obstructive pulmonary disease, cystic fibrosis, moderate or severe asthma, and bronchopulmonary dysplasia), diabetes mellitus, or haemoglobinopathies
• Those with immunosuppression due to disease or treatment, including asplenia or hyposplenism, and all cancer patients
• Those with any condition that can compromise respiratory function (e.g. spinal cord injury, seizure disorder, or other neuromuscular disorder,) especially those attending special schools/ day centres
• Children and adults with Down syndrome
• Children with moderate to severe neurodevelopmental disorders such as cerebral palsy and intellectual disability
• Children on long-term aspirin therapy (because of the risk of Reye syndrome)
• Those with morbid obesity (Body mass index >40)
• Residents of nursing homes, old people's homes, and other long stay facilities where rapid spread is likely to follow introduction of infection
4: Those likely to transmit influenza to a person at high risk for influenza complications (section iii)
• Health Care Workers (HCWs), both for their own protection and for the protection of patients who may have a suboptimal response to influenza vaccinations (Chapters 3 and 4)
• Household contacts of at-risk persons
• Out-of-home care givers to at-risk persons.
5: All pregnant women at any stage of pregnancy
Pregnancy increases the risk of complications from influenza because of alterations in heart rate, lung capacity, and immunological function. It is estimated that immunisation could prevent 1-2 hospitalisations per 1,000 pregnant women. Because inactivated influenza virus vaccine is not a live vaccine it is very safe in pregnancy.
6: People who have close, regular contact with pigs, poultry or water fowl.

Exclusion Criteria for pharmacy administration of the influenza vaccination:

1. Previous anaphylaxis to vaccine or any of its components or excipients.
2. Hypersensitivity to the active substances, to any of the excipients, to residues, to egg and to chicken protein.
3. Immunosuppressed patients (Antibody response in patients with endogenous or iatrogenic immunosuppression may be insufficient.)

Vaccination should be postponed in the case of:

1. An acute infection or if you are feeling unwell in any way.

Patient advice:

1. Being vaccinated is likely to provide effective protection against this year's strain of the winter flu virus; however there will be a small chance of you catching the flu.
2. This year's winter flu vaccination includes protection again the H1N1 (swine flu) virus.
3. After vaccination it takes 10-21 days to be protected against flu. You cannot catch flu from the flu vaccination. If you are exposed to the flu virus before you are fully protected from the flu virus then you may still catch the flu.
4. Blood tests for HIV, hepatitis C and HTLV1 should not be taken for two weeks following vaccination because there is a possibility of a false positive reading.
5. On rare occasions, anaphylaxis may occur. We have procedures in place to deal with this.
6. If you are concerned about any aspects of your vaccination or about any symptoms or side effects, you should talk to your pharmacist immediately.
7. If you have a condition that affects your immune system or are taking long term medicines for such condition, and this is the first time you have received the flu vaccine, you may require a second dose in four weeks time.

Patient consultation form for the Influenza Vaccination

Personal Details:

Mr/Miss/Mrs/Ms/Other: _____

Surname: _____

First name: _____

Please circle: Male Female

Date of birth: _____ /___ / ___

Age: _____

Address: _____

_____

Phone number: _____

Medical Card/GMS: _____

PPSN: _____

GP Name and Address: _____

_____

_____

Do you consent to the pharmacy informing your GP that you have received your influenza vaccination? (please circle)

Yes No

Medical History:

Please circle the correct answer:

Are you under the age of 18?	YES	NO
Are you pregnant or breastfeeding?	YES	NO
Have you had breast surgery?	YES	NO
Do you feel unwell, have a temperature or an infection?	YES	NO
Are you allergic to eggs or chicken?	YES	NO
Have you ever had an allergic reaction to any previous vaccinations?	YES	NO
Have you ever suffered from an anaphylaxis attack?	YES	NO
Have you ever had an allergic reaction to latex?	YES	NO
Have you been told in the last three months that you are immunocompromised or immunosuppressed? (Usually as a result of treatment for cancer eg: radiotherapy, chemotherapy or medication such as methotrexate or oral steroids taken daily for more than three weeks)	YES	NO
Do you suffer from a bleeding disorder or are you taking anticoagulant medication such as warfarin?	YES	NO

Please indicate any other allergies or medical conditions:

_____

_____

_____

_____

_____

_____

Patient Consent Form for the influenza vaccination

I confirm that I have read and understood the contents of this leaflet and confirm that the information provided is correct to the best of my knowledge.

I also confirm that I have had an opportunity to speak to the pharmacist providing the vaccine and I understand that the vaccine will only be offered if the pharmacist believes the vaccination is appropriate to me.

I understand that if I have supplied my GP details then the pharmacist has an obligation to inform my GP of my vaccination.

I confirm that I am aware that I should remain instore for at least 15 minutes for observation after the administration of the vaccination.

I understand the risk of anaphylaxis as a result of the administration of the vaccination and I consent to the pharmacist administering an Anapen to me in the event of such a reaction.

I am happy to proceed with the vaccination for Influenza:	I do not wish to receive vaccination for Influenza:
Signed: (or Guardian) Date:	Signed: Date:

Time of administration of the vaccine:_____

Time which the patient left the store:_____

If the patient chooses to leave the store before the 15 minutes have passed then please ensure they sign the below declaration:

I, the patient, was advised to wait in the pharmacy for 15 minutes post vaccine administration. However, against the pharmacist's advice, I chose to leave before the 15 minutes passed.

Signature of patient (or Guardian) :_____

Date:_____

Signature of Pharmacist:_____

PSI number of Pharmacist:_____

Date:_____

6 August 2020

National Immunisation Advisory Committee Statement on post immunisation advice related to COVID-19

Given the risk of the serious infections that vaccines protect against, the National Immunisation Advisory Committee strongly recommends that the National Immunisation Programmes should continue as usual.

Post immunisation fever

Fever commonly occurs after immunisation and is a normal part of the inflammatory response.

Parents, carers and patients may be concerned that, if they or their child develop a fever following immunisation, they or their child may need further investigation to outrule COVID-19.

The following outlines the expected time frame and characteristics of fever post vaccination when further investigation may not be needed.

Non-live (inactivated) vaccine febrile reactions

Fever after non- live* (inactivated) vaccines usually starts within 24 hours after vaccination. Fever is generally mild (<39oC) and usually resolves within 2-3 days without treatment. This is a common, expected reaction.

Further investigation is not required if a mild fever develops as above, within 72 hours of vaccination, unless COVID-19 is suspected.

Fever is more common when Meningococcal B (MenB) vaccine (Bexsero) is given with other vaccines at 2 and 4 months of age. Advice to give paracetamol after MenB vaccination remains unchanged.

Live vaccine febrile reactions

Live attenuated influenza vaccine (LAIV): Mild fever (<39oC), nasal congestion, rhinitis, malaise and decreased appetite are common reactions expected after LAIV. Symptoms associated with the administration of LAIV usually take about 24 hours to develop and usually resolve without treatment within 72 hours.

Further investigation is not required if the mild symptoms develop as above, within 72 hours after LAIV, unless COVID-19 is suspected.

Measles, mumps, rubella (MMR) vaccine: Mild fever (<39oC) is a common reaction and usually occurs 1-3 weeks after vaccination.

Because of the longer timeframe for the development of fever post MMR vaccination, standard COVID-19 investigation procedures should be followed.

Note:

Clinical judgement should be used based on the individual case. Parents, carers or patients should be advised that if they are concerned about their or their child's health, they should seek advice from their GP. This advice applies to recently vaccinated people of all ages.

*e.g. 6in1, PCV, MenB, MenC, Hib/MenC, inactivated influenza vaccines

Vaccination Record

Reference Number

PATIENT DETAILS

*PPSN

*Card No.

*Patient's Name

Address

*Date of Birth

*Gender

Increased Medical Risk Code

TO BE COMPLETED IN WRITING BY PATIENT OR GUARDIAN

1. I verify that I have received an injection of
   - Influenza ☐
   - Pneumococcal ☐
   - Herpes Zoster (Shingles) ☐
2. I confirm that I consented to have myself / the above named person vaccinated with
   - Influenza ☐
   - Pneumococcal ☐
   - Herpes Zoster (Shingles) ☐
3. **Data Protection Notice**: Personal data collected by HSE PCRS is used for the purpose of providing a health service. It is required, stored, processed and disclosed to other bodies in accordance with the laws relating to proper treatment of personal data.

Signature (Mandatory)

_____

PRACTITIONER DETAILS

*Contractor No.

*Contractor's Name

Address

The vaccination detailed hereon has been given by me.
*SIGNATURE AND STAMP OF CONTRACTOR

If different from above, then please provide details, in BLOCK CAPITALS, of person administering the vaccine

*Professional Reg. No.:

*Cold Chain Acc. No.:

**INCREASED MEDICAL RISK CODES

A ☐	B ☐	C ☐	D ☐	E ☐
F ☐	G ☐	H ☐	I ☐	J ☐
K ☐	L ☐	M ☐	O ☐	P ☐
Q ☐	R ☐	S ☐	T ☐	U ☐
V ☐	W ☐	X ☐	Y ☐	Z ☐
AA ☐	AB ☐	AC ☐	AD ☐	AE ☐
AF ☐	AG ☐	AH ☐	AI ☐	AJ ☐
AK ☐	AL ☐			

VACCINATION DETAILS

*** Vaccination Date**

DD / MM / YYYY

Batch Number

Name of Vaccine

Manufacturer

Injection Site

Expiry Date

Vacc. Type

Shot 1 ☐

_____

Batch Number

Name of Vaccine

Manufacturer

Injection Site

Expiry Date

Vacc. Type

Shot 1 ☐

* Mandatory fields
** At least one required for payment

Contractors should retain copies of this paperwork for their own records and audit if required.