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# Consent Form ~ Influenza Vaccine

Name_____Date of Birth _____

Address_____

Telephone Number _____

- **Before consenting to receiving the influenza vaccination, please read the "Influenza Information Sheet/Brochure" provided to you prior to vaccination**
- **Please read the questions below and if you answer yes to any of the questions please discuss with your immunisation provider.**

***The information you provide is private and confidential and will not be used for any other purpose.***

## Questions for discussion *(Please tick appropriate boxes)*

| | | | |
|---|---|---|---|
| 1 | Do you have an acute feverish illness at present? | Yes ☐ | No ☐ |
| 2 | Have you been vaccinated against the flu in previous years? | Yes ☐ | No ☐ |
| 3 | Have you experienced any significant problems after vaccination? | Yes ☐ | No ☐ |
| 4 | Are you allergic to eggs or chicken feathers? | Yes ☐ | No ☐ |
| 5 | Are you allergic to neomycin, polymyxin or gentamicin? | Yes ☐ | No ☐ |
| 6 | Are you taking any cortisone, steroid, immunosuppressive medication or theophylline, warfarin or dilantin? | Yes ☐ | No ☐ |
| | If ***Yes***, please specify _____ | | |
| 7 | Have you ever fainted when given an injection? | Yes ☐ | No ☐ |
| 8 | FOR WOMEN: Are you pregnant or breastfeeding? | Yes ☐ | No ☐ |

## Consent

**I have read and understood the Influenza Information Sheet about the risks of influenza vaccination including the risks of not being vaccinated.**

**I have been given the opportunity to discuss the risks and benefits with my immunisation provider.**

**I consent to receiving the influenza vaccine injection and inclusion on staff data base.**

**I understand that consent can be withdrawn at any time prior to vaccination.**

**Signature** _____ **Date** _____

## For Office Use Only

Date Given _____ Review Date _____

Batch Number _____ Brand_____

Site - Deltoid *(tick box)* L ☐ R ☐ Influenza Vaccine given by RH MM RM NAMC DH PLR KA ML

Provider Signature _____