Pivotalhealth

Consent Form - Influenza Vaccine

Mr/Mrs/Ms/Miss/Dr Surname: ..... **Given Name:** .....

Date of Birth: .....

Before consenting to receiving the influenza vaccination, please read the "Influenza Information 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.

Please answer the following questions before consenting to receiving the influenza vaccine		
Do you have an acute feverish illness at present?	Yes	No
Have you been vaccinated against the flu in previous years?	Yes	No
Have you experienced any significant problems after vaccination?	Yes	No
Are you allergic to eggs or chicken feathers?	Yes	No
Do you have any allergies?	Yes	No
If Yes, please specify:		
Are you currently taking any prescription medication?	Yes	No
If Yes, please specify:		
Have you ever fainted when given an injection?	Yes	No
FOR WOMEN: Are you planning a pregnancy, pregnant or breastfeeding?	Yes	No

Please sign below to acknowledge that the information provided above is correct and that you are aware of our Practice Privacy Policy, Practice Drugs of Addiction Policy, and Practice Billing Policy.

Patient's Signature: ..... **Date**: .....

We are constantly looking for ways to improve our service. If you have any feedback for us, please email us at reception@pivotalhealth.com.au

For Office use only	
Is the patient well today?	
Allergies, previous vaccination and current medication checked?	
Patient given opportunity to ask questions?	
Post Vaccination Information given?	
Date given	
Brand & Batch number	
Given by: (stamp)	