INFLUENZA VACCINATION CONSENT FORM 2017

Please complete all sections and give directly to the nurse

The purpose of this form is to advise the nurse of any contra-indications you may have to the vaccine and that you are giving your consent to have the influenza vaccine.

Your Full Name:_____ Date of Birth: ____/____/____

Company Name: _____ Family Doctor/GP: _____

To the best of your knowledge:

Are you currently unwell with a high fever?	Yes/No
Have you had a flu vaccination before?	Yes/No
Have you had a reaction to an injection or vaccination?	Yes/No
Are you allergic to eggs or any other poultry products?	Yes/No
Are you allergic to latex?	Yes/No
Are you allergic to any medicines? Please list: _____	Yes/No
Do you have a bleeding disorder?	Yes/No
Do you have, or have you had cancer?	Yes/No
Have you had Guillain-Barré Syndrome (paralysis problem)?	Yes/No
Do you have any of the following: *cardio-vascular, chronic respiratory, renal disease or diabetes?*	Yes/No
Do you have any other health conditions?	Yes/No

Please list prescription medication and conditions below:

_____

_____

Influenza vaccine is usually well tolerated; however possible responses to the influenza vaccine include, but are not limited to:

- Redness, tenderness or a hardness at the injection site for a day or two
- A mild fever, muscle ache or headache within the first 2 days
- Rarely, an allergic reaction can occur almost immediately

Influenza vaccination is highly effective but cannot guarantee complete protection against catching influenza. Protection becomes effective 2-3 weeks after vaccination. If you come in contact with the influenza virus within two weeks of being vaccinated, you may still contract the virus.

YOU CANNOT GET THE FLU FROM HAVING THE FLU VACCINATION!

You must remain onsite for 20 minutes after your vaccination. Please notify our nurse immediately if you have any concerns. Make sure you take your After Immunisation Leaflet, complete the slip on the bottom and send to your family doctor.

At this time, I believe the above information I have given is true and correct. I have read and understood the above information and asked questions as required. I understand the information given will not be used for anything else that will identify me and is solely for the use of the nurse here today from Maxwell Health. I consent to having the influenza vaccination today.

Date: ___/___/2017 *Signed:* _____

Maxwell Health collects and stores this information only for the purpose of your vaccination today.

NURSE USE ONLY

L)arm

R)arm

Batch No./Expiry Date:

Signature of Vaccinating Nurse:

Nurses Stamp: