**INFLUENZA CONSENT FORM**

Please read the *Fact about Influenza* prior to consenting to receiving the influenza vaccination.

|  |  |
| --- | --- |
| **Employer Name** |  |
| Employee Name |  |
| Position |  |
| Date of Birth |  |

**Employee Details**

**Questions for Discussion:**

Please circle either “Yes” or “No” for each question below. When you answer “Yes” to a question, please discuss with your immunisation provider. Please note: The information you provide is private and confidential and will not be used for any other purpose.

(Please circle one option)

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 a vaccination? Yes No

Are you allergic to eggs or chicken feathers? Yes No

Are you taking any cortisone, steroid, immunosuppressive

medication or theophylline, warfarin or dilantin? Yes No

If **Yes,** please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever fainted when given an injection? Yes No

FOR WOMEN ONLY: Are you pregnant or breastfeeding? Yes No

**Consent**

I have read and understood the Influenza Information Brochure about the risks of influenza vaccine, including the risks of not being vaccinated.

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

I consent to receiving the influenza vaccine injection and inclusion on staff database.

I understand that consent can be withdrawn at any time prior to vaccination.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­\_\_\_/\_\_\_/\_\_\_

**OFFICE USE ONLY**

**Date Given:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Batch Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Brand:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Site: Deltoid (Circle): Left Right**

**Personal vaccination record given? (Circle): Yes No**

**Influenza Vaccine given by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_