Belair
FAMILY HEALTH CENTRE
FAMILY PRACTICE IN THE HILLS
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Consent Form - Influenza Vaccine

Name:_____ Date of Birth _____

Address _____

Telephone Number_____

- **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.

Consent

Questions for discussion (Please circle 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, 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 ?	YES	/	NO

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I understand that consent can be withdrawn at any time prior to vaccination.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 L R Influenza vaccine given by RN _____

Provider Signature _____