

# INFLUENZA IMMUNISATION CONSENT FORM

Full name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Name of doctor or organisation: \_\_\_\_\_

**This form confirms for our records that you have given your consent to have the inFLUenza vaccine.**

**1. To confirm that you qualify for free vaccine, please tick which of the following conditions you have:**

Cardiovascular disease

YES

Chronic respiratory disease (including asthma if on regular preventative treatment)

Diabetes

Chronic renal disease

Other (please specify)

**2. If any of the following apply, please tick and consult your doctor:**

I am pregnant

I have a bleeding disorder

I have experienced health problems such as immunodeficiency disorders or other

I am allergic to eggs

I am currently taking medication

I have, or have had, Guillian-Barré syndrome

I am allergic to neomycin, polymyxin

**3. InFLUenza immunisation should not be given to anyone with:**

Acute respiratory illness or high fever

Previous hypersensitivity (anaphylaxis) to any component in an inFLUenza vaccines

**Ensure you have discussed the above with your doctor**

**4. Possible reactions**

InFLUenza immunisation is usually well tolerated. Possible reactions include 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.

**You should remain under observation for 20 minutes after your immunisation.**

I consent that this information be given to my healthcare provider to update applicable records. I have read and understood the above information.

Signed:

Date:

**Immunisation Record:**

Vaccine batch No:

Expiry:

Administered:    Left arm                  Right arm

Given by: