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INFLUENZA VACCINE CONSENT FORM

Please answer the following questions to allow us to access your suitability to receive the flu vaccination:

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| 1. Is this the first time you have received the the influenza vaccination? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. Have you ever experienced any significant problems after any vaccination? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Do you have an acute illness with fever at present? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. Are you immunocompromised? <i>If yes, please specify</i> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. Are you allergic to any of the following: neomycin, polymyxin, gentamicin or latex?
<i>If yes, please specify</i> | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6. Have you ever had Guillain Barre Syndrome? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

POSSIBLE SIDE EFFECTS OF VACCINATION

Like all medicines, the influenza vaccine can cause side effects, although not everybody gets them. The most common side effects of the influenza vaccine include:

- Pain, tenderness, redness, swelling, bruising and hardness at the injection site
- Systemic side effects including:
 - Feeling generally unwell (malaise)
 - Muscle aches
 - Headache
 - Shivering
- Fever
- Irritability
- In children: abnormal crying, drowsiness, appetite loss, vomiting

These side effects usually resolve within a few days. If events continue or become severe, or if you notice something not listed in this leaflet, please tell your doctor.

It is recommended that all people who receive the influenza vaccination remain in the vicinity for 15 minutes in case of an allergic response.

What to do to reduce side effects?

- Drink extra fluids
- Rest
- Paracetamol can be given as per the instructions on the bottle/pack
- Do not overdress if hot
- Seek further advice from your doctor if concerned

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND CONSENT TO RECEIVING THE INFLUENZA VACCINE

Full Name: DOB: / / Age:

Signature: Date: / /

Doctors Name:

Doctor Signature: Date: / /

Brand:	Site given:	Administered by:
LOT/ Exp:	Funded : YES / NO	Signature: