HEALTH AND IMMUNISATION MANAGEMENT SERVICES

Influenza Consent Form

Surname: _____ **Given Name**_____

Address_____**Suburb**_____**Postcode**_____

Medicare Card: (10 digit) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ **Ref No.** ___ *** number next to name on card**

Telephone_____ **Date of Birth**_____ **MALE** **FEMALE**

Organisation_____

Pre Vaccination Questionnaire	**Please circle answer**	
Are you allergic to egg or chicken feathers?	Yes	No
Are you taking Warfarin (blood thinner) or Theophylline (Asthma medication)?	Yes	No
Have you ever in previous years received an Influenza Vaccine?	Yes	No
Are you allergic to Neomycin or Polymixin (Antibiotic)?	Yes	No
Have you ever suffered from Guillian Barre (a rare post viral infection)?	Yes	No
Have you ever fainted when given an injection?	Yes	No
Do you identify as Aboriginal or Torres Strait Islander?	Yes	No
Are you 65 years of age or over?	Yes	No
Are you Pregnant? (This is not a contraindication for influenza vaccination)	Yes	No

I have read and understood the information given to me about immunisation including the risks of the vaccination and the risks of not being vaccinated. I have been given the opportunity to discuss the risks and benefits with my nurse. I understand that consent can be withdrawn at any time. I understand the information I provide, and information related to any vaccines administered, will be recorded electronically and/or in hard copy for the purposes of recording onto The Australian Immunisation Register.

It is advisable to wait 15 minutes after vaccination before leaving and 30 minutes before driving and operating machinery

Print name:_____

Signature of the person to be vaccinated:_____ **Date**:_____

Office Use Only

RN Name_____Signature_____

Date _____Time Given_____Vaccine Brand_____Vaccine Batch_____

RN Please circle **LA** **RA** **MAR** **FEE**