WorkingHealth
stay well at work

Consent Form – Influenza 2017

Please use block letters to complete your consent form, we will notify your family doctor that you have been vaccinated

Family Name		Given Name	
Date of birth		Company	
Doctor		Medical Centre	

History

Please tick Yes or No for the following	Yes	No
Are you currently taking any medication?		
Have you ever had a serious reaction to a vaccination?		
Have you ever had severe allergic reaction to anything?		
Are you allergic to neomycin, polymyxin B Sulfate, gentamicin		
Are you allergic to any chicken protein, eg eggs, chicken meat, or chicken feathers?		
Have you had a recent respiratory (chest) illness and/or high fever?		
Do you, or have you had, Guillian-Barré Syndrome?		
Do you have a blood disorder (eg haemophilia)?		
Have you had immunodeficiency disorders?		
Are you, or could you be, pregnant?		

Please Read

Normal side effects from this vaccination (which may last a few days) are:

- Some redness and tenderness at the injection site for 24-48 hours
- Occasional mild fever, muscle aches, and headaches, within two days

Severe allergic reactions are very rare and can be managed by a health professional. This is why you must be observed for 20 minutes after your vaccination.

I have read and understood the information provided and consent to have an influenza vaccination. I agree to wait in the designated area as instructed by the nurse for 20 minutes following my vaccination. I consent to this information being given to my doctor to update applicable records .

Signed: ______________________________ *Date*______________________

Vaccinator to Complete

Nurse Signature:			
Nurses Initials:		Date	
Vaccination Site:	☐ LD ☐ RD	Batch / expiry	