Influenza Vaccination Consent form 2019

Family Name		Given Name	
DOB		Company	
Doctor **Please write clearly**		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 (these are types of antibiotics)		
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? (rare neurological **disorder** in which the body's immune system mistakenly attacks part of its peripheral nervous system)		
Do you have a blood disorder (eg haemophilia)?		
Have you had immunodeficiency disorders?		
Do you currently have cancer or are you being treated for cancer? (are you taking any of these medications: • atezolizumab (Tecentriq®), • ipilimumab (Yervoy®), • nivolumab (Opdivo®) • pembrolizumab (Keytruda®)		
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
- The influenza vaccine does not protect against other respiratory viruses such as the common cold.
- For more information on the influenza vaccine please refer to the Consumer Medicine Information located at www.medsafe.govt.nz

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 in the event of an adverse reaction.

Signed: _____ *Date* _____

Vaccinator to Complete

Nurses signature		Date	
Vaccination Site:	□ LD □ RD	Batch / expiry	