AIR | Imps

Health & 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**

Email_____**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 risk of the vaccination and the risk of not being vaccinated. I have been given the opportunity to discuss the risks and benefits with the nurse. I consent for the above named to be vaccinated with the vaccines as indicated. **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**

FEBRUARY 2017