

Flu Vaccination consent form



Company: _____

Client:

Surname: _____ First name: _____

Phone: _____ Date of birth: _____ M F NHI: _____

Address: _____

Your doctor's name / surgery address: _____

This form confirms that you have given your consent to have the influenza vaccine for our records.

If any of the following apply to you then please consult your healthcare professional:

- I am currently unwell with a high fever I have had a previous severe reaction to an influenza vaccine
 I have a history of a bleeding disorder I have a severe allergy to eggs and / or any poultry products

Possible reactions to influenza immunisation:

Influenza immunisation is usually well tolerated. Possible reactions include redness, tenderness or hardness at the injection site for a day or two; a mild fever, muscle aches or headache within the first two days. Rarely, an allergic reaction can occur.

You should remain under observation to watch for allergic reactions for 20 minutes after your immunisation.

Influenza immunisation is usually effective but cannot guarantee complete protection against catching influenza. 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.

The Ministry of Health keeps a record of influenza immunisation on the National Immunisation Register so that authorised health professionals can find out what immunisations have been given. It helps to monitor the population's protection against influenza. If you do not want your immunisation recorded on the National Immunisation Register please advise your doctor, nurse or healthcare professional.

I have read or have had explained to me information about influenza vaccine, and I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccination. I understand getting the vaccine is my choice. I agree to get the vaccine and that it is recommended that I wait here for 20 minutes after my vaccination.

I consent to this information being given to my healthcare provider to update applicable records.

Signed: _____ Date: _____

Immunisation Record (for Clinic Use Only)

Vaccine: _____ Administered: Left / Right Arm

Vaccine Batch Number: _____ Vaccinator: _____

Expiry Date: _____

The influenza vaccine is a Prescription Medicine. Talk to your healthcare professional about the benefits and possible risks.