



IRIS

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 I understand that consent can be withdrawn at any time.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. I consent to the disclosure of this information to SA Health and local government councils (and their immunisation service providers, HAIMS) and to the Australian Immunisation Register. I can contact my immunisation service provider (HAIMS) if I am concerned personal information has been misused or subject to unauthorised access. If the issue remains unresolved, contact SA Health on 1300 232 272.

Name of person giving consent: _____ Signature: _____

*Relationship to person being vaccinated: _____ DATE ____/____/____

***If person being immunised is under 16 then Parent or Guardian must consent**

Office Use Only

RN Name _____ Signature _____

Date _____ Time Given _____ Vaccine Brand _____ Vaccine Batch _____

RN Please circle LA RA MAR FEE