Influenza Consent Form

Health and Immunisation Management Services

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 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 I understand that consent can be withdrawn at any time.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 where it will be recorded on my Medicare account. 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 It is advisable to wait 15 minutes after vaccination before leaving and 30 minutes before driving and operating machinery

(If person being vaccinated is under 16 then the Parent or Guardian must sign and consent)

***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**

Date of Issue January 2023 Approved by Lee Frayne (Director)
Printed version may be superseded refer to Online Quality System for current version.