

# Corporate Vaccination Services



## Flu Vaccination Questionnaire & Consent Form

Please print clearly

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male / Female

Employer: \_\_\_\_\_

**If you would like an Influenza Vaccination, please answer the following questions.**

- |   |     |    |
|---|-----|----|
| 1. Are you taking any medication now? (eg: antibiotics, phenytoin, theophylline)                                    | YES | NO |
| If yes please specify _____   |     |    |
| 2. Are you allergic to anything? (eg: eggs, chicken feathers, neomycin, gentamycin, bandaids)                       | YES | NO |
| If yes please specify _____   |     |    |
| 3. Have you ever felt faint or fainted after an injection or giving blood?  | YES | NO |
| 4. Are you suffering an acute illness with fever? (above 38.5°C)  | YES | NO |
| 5. Are you pregnant or breastfeeding?   | YES | NO |
| 6. Have you had Guillian Barre Syndrome? (a neurological, paralysing condition diagnosed by a medical practitioner) | YES | NO |

### Mild side effects (common)

- Redness, swelling, a hard lump, soreness, bruising or itching around the injection site
- Muscle aches and pains

### More serious side effects (uncommon)

- Severe skin reactions
- Shortness of breath
- Unusual tiredness or weakness that is sudden and severe

*This information is private and confidential and will not be used for any other purpose.*

### CONSENT FOR VACCINATION

I have read and understood this information and consent to receiving an influenza vaccine.

I also understand that I should stay within the immediate vicinity of the health professional for 15 minutes after my vaccination.

I consent to the administration of the vaccine.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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### FOR DOCTOR/REGISTERED NURSE ONLY.

Vaccine \_\_\_\_\_ Batch No \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_