SEASONAL INFLUENZA VACCINE CONSENT FORM

2009-2010

Last name: _____ First name: _____

Street Address: _____ Phone number: _____

City: _____ Postal Code: _____ Do you have a long-term medical condition? No ☐ Yes ☐

Date of Birth: Year _____ Month _____ Day _____ Age: _____ Male ☐ Female ☐

Are you a Health Care Worker? No ☐ Yes ☐ Are you an Emergency Service Worker? No ☐ Yes ☐

Are you feeling ill?	No ☐	Yes ☐	If yes, please explain below
Have you ever had a flu shot before?	No ☐	Yes ☐	
If yes, did you have any problems after the shot?	No ☐	Yes ☐	If yes, please explain below
Have you ever had an allergic reaction to a vaccine?	No ☐	Yes ☐	If yes, please explain below
Are you allergic to eggs or egg products?	No ☐	Yes ☐	If yes, please explain below
Are you allergic to any of the following components of the vaccine?			
formaldehyde	No ☐	Yes ☐	If yes, please explain below
thimerosal (mercury)	No ☐	Yes ☐	If yes, please explain below
neomycin (**Vaxigrip® only**)	No ☐	Yes ☐	If yes, please explain below
Triton® X-100 (**Vaxigrip® only**)	No ☐	Yes ☐	If yes, please explain below
deoxycholate (**Fluviral® only**)	No ☐	Yes ☐	If yes, please explain below
Do you have a bleeding disorder?	No ☐	Yes ☐	If yes, please explain below
Are you taking any medication that could affect blood clotting?	No ☐	Yes ☐	If yes, please explain below
Have you ever been diagnosed with Guillain-Barré Syndrome?	No ☐	Yes ☐	If yes, please explain below

Please explain any "Yes" answers provided above: _____

_____

I have read (or it has been read to me) and I understand the "Seasonal Influenza Vaccine Information Sheet". I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to the seasonal influenza vaccine. In addition, I am aware that personal health information collected on this form may be shared with another doctor or nurse if that is required for my care. Should you not want your information released to another doctor or nurse, please check below or advise the Health Unit in writing.

If signing for someone other than yourself, indicate your relationship to that other person: _____
If signing for someone other than yourself, you must be the appropriate substitute decision maker.

Signature**:** _____ Print**:** _____

Date of signature: _____

Please check if you do not want your information released to another doctor or nurse. ❒

For Clinic Use Only:

Vaccine	Dose	Site	Lot Number	Date Given	Time Given	Given By
Fluviral® **OR** Vaxigrip®	ml IM					

For children 6 months of age to less than 9 years of age receiving their second influenza vaccine in 2009-2010:
Date of first dose _____
Comments:_____

Notice of Collection: Personal information is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990. It is collected to maintain a record of your immunization and to provide statistics required by the Middlesex-London Health Unit and the Ministry of Health and Long-Term Care. Should you have questions about the collection and maintenance of this information, please contact Dr. Bryna Warshawsky at 519-663-5317 ext. 2330.

(*Revised October 4, 2009)*