**INFLUENZA COMPANY**

 **VACCINATION CONSENT**

**2018**

 **Pre-Vaccination Checklist**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PLEASE CIRCLE YES / NO (circle one)**

|  |  |
| --- | --- |
| Allergies | YES / NO |
| Previous Influenza vaccinations | YES / NO |
| Previous reactions/problems with Influenza vaccination | YES / NO |
| Have you discussed risks and side effects of influenza vaccination with vaccine provider? (Possible side effects include-allergic reactions, fevers, muscle aches and pain, localised redness, pain and swelling, infection at vaccination site.)Rarely this may include serious allergic reaction (anaphylaxis) high fevers, seizures and death. | YES / NO |
| Is your immune system compromised because of a disease or treatment for a disease? (Examples of this are: current or recent treatment (within 6 months) with chemotherapy or radiotherapy, high doses of steroids (>20mg per day for<2 weeks) or other drugs that affect the immune system, recen6t organ or bone marrow transplant.) | YES / NO |
| Is your immune system suppressed because of HIV infection? | YES / NO |
| Have you had a blood transfusion in the last 3 months? | YES / NO |
| Females only – are you pregnant? Are you breastfeeding? | YES / NO |
| Have you received any other vaccinations in the last 4 weeks? | YES / NO |

If you have any concerns, please discuss these with the nurse prior to your vaccination.

If you have any problems please contact Family Doctors Plus on **33578192** or ring **000.**

**CONSENT:**  I consent to having the vaccine and have read all the information above. The information completed by me is true and correct to the best of my knowledge. I am aware of the side effects of the vaccine and I am aware all vaccines have side effects which may not be listed above. The cost of the Influenza Vaccine is covered by The Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO BEING VACCINATED WITH INFLUENZA VACCINATION YES / NO**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

***FAMILY DOCTORS PLUS***

***UNIT 2/178 ALBION ROAD WINDSOR 4030***

***PH: 3357 8192***