

Influenza Consent

Please print clearly

Last Name		First Name	
Date of Birth		Employee Number	
Company		Division	

If you would like influenza vaccination, please answer the following questions ...

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| Are you allergic to egg or chicken? | Yes / No |
| Are you allergic to Neomycin? | Yes / No |
| Are you suffering an acute illness with fever at present? | Yes / No |
| Have you been vaccinated against Influenza in previous years? | Yes / No |
| Are you presently taking Warfarin, Theophylline or Dilantin? | Yes / No |
| Are you pregnant or breastfeeding? (Recommended but please discuss with Nurse) | Yes / No |
| Have you ever felt faint or fainted after an injection or giving blood? | Yes / No |

Side effects:

The Influenza vaccine is generally well tolerated. Most unwanted side effects are mild and clear up within a few days. These effects generally occur around the injection site.

More common side effects include . . .

- Redness, swelling, a hard lump, soreness, bruising or itching around the injection site
- Muscle aches and pains, tiredness.
- Much less commonly: Fever, chills, headache and a general feeling of being unwell that may last 1-2 days.

More serious, but rare effects include . . .

- Immediate reactions such as hives, itching (especially of the hands and feet) and/or reddening of the skin, other more severe skin reactions.
- Shortness of breath, breathing or swallowing difficulties.
- A significant increase in Guillain-Barre Syndrome (GBS), a rare disease affecting nerves, was associated with an influenza vaccine used in 1976. Subsequent to this, the excess risk of GBS associated with influenza vaccine has been estimated as 1 per million doses. If you have suffered from GBS in the past, please inform us before vaccination.

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

Consent for vaccination

<p>I have read and have understood this information and consent to receiving an influenza vaccine. I also understand that I must stay within the immediate vicinity of the health professional for 15 minutes after my vaccination. I consent to the administration of the influenza vaccine.</p>	<p>Signature: _____ Date: _____</p>
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