

CONSENT FOR INFLUENZA IMMUNIZATION

I have received and read the **Fact Sheet** about **influenza vaccine**. I have had a chance to ask questions which were answered to my satisfaction and understand the benefits and risks of the vaccine.

I consent to this vaccine being given to:

PLEASE PRINT CLEARLY

Name: (Surname) _____ (First Name) _____	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Date of Birth: (yy/mm/dd) _____	Age: _____
Home Address: _____	
City: _____	Telephone: _____
Health Card # _____	Postal Code: _____

Does the individual who is to be immunized have any of the following:

Nurses
Initials

- Allergies to any vaccine components (neomycin, thimerosal, eggs, latex)? Yes No _____
If yes, list: _____
- Fever, febrile illness? Yes No _____
- Blood disorder or any health condition that affects their immune system? Yes No _____
If yes, list: _____
- Do you consider yourself to be in a high-risk group (over 65, health care worker, care giver, cardiac or pulmonary illness)? Yes No _____
- History of adverse reactions to the Influenza vaccine (GBS, ORS)? Yes No _____

Signature: _____
(Client) (Parent/Legal Guardian)

Date: _____

Please print name of parent/legal guardian _____

<p>Age group (please check one box):</p> <p><input type="checkbox"/> 6 months to 35 months</p> <p><input type="checkbox"/> 3 years to 8 years (Prior to 9th birthday)</p> <p><input type="checkbox"/> 9 years and older</p>	<p>For clinic use only:</p> <p>0.25 ml IM, 2nd dose may be needed</p> <p>0.5 ml IM, 2nd dose may be needed</p> <p>0.5 ml IM, 1 dose only</p>
--	---

Office (Clinic Use Only)

Nurses Comments: _____

Date	Time	Vaccine	Dose	Mode	Site	Lot No.	Nurse Signature
				IM	L R		

This information is collected for the purpose of maintaining an immunization record for this individual. It will be maintained in confidence by your vaccine provider. Should you have questions about the collection and maintenance of this information, please contact the Windsor-Essex County Health Unit, 258-2146.