☐ Eastern Health ☐ Central Health ☐ Western Health ☐ Labrador-Grenfell Health

# Seasonal Influenza Immunization Consent & Record of Immunization Form

**Does the child require two doses this season:** ☐ **Yes** ☐ **No**

**If yes, which dose is child receiving today:** ☐ **Dose 1** ☐ **Dose 2**

| | |
|---|---|
| **MCP Number:** | |
| **Last Name:** | **First Name:** |
| **Date of Birth (dd/mm/yyyy):** | **Telephone:** |
| **Address:** | **Postal Code:** |

**Age Group:** ☐ 6 mths–4 yrs ☐ 5–8 yrs ☐ 9–19 yrs ☐ 20–44 yrs ☐ 45-64yrs ☐ ≥ 65 yrs

**Are you pregnant?** ☐ Yes ☐ No

| Screening Questions | check the correct box | | |
|---|---|---|---|
| | **Yes** | **No** | **Unsure** |
| Are you a Health Care Worker? | | | |
| Are you sick or do you have a fever today? | | | |
| Do you have any past or present medical conditions? If yes, please describe. | | | |
| Do you have a history of allergies? (medications, vaccine, eggs, food). If yes, please list | | | |
| Have you ever had the flu shot before? | | | |
| Have you ever had a reaction to a flu shot? (red eyes, hives, rash, or difficulty breathing). If yes, please describe. | | | |

## Adverse Reactions

1. Common side effects with injection are soreness and redness at the injection site that may last up to 2 days.
2. Less often side effects include headache, muscular aches/pains, red eyes, cough, irritability and sore throat.
3. Allergic reactions such as breathing problems and hives are very rare and may occur with extreme sensitivity to certain components of the vaccine.

**CONSENT**

I understand the information regarding the benefits & risks of the seasonal influenza vaccine provided by the Health Care Provider.

I **CONSENT** for me or my dependant to have the seasonal influenza vaccine, two (2) doses for children under age nine (9) years with no prior seasonal influenza vaccine.

Signature: _____

Relationship to child/person: _____

Date: _____

## To be completed by Health Care Provider administering Influenza vaccine

| | | |
|---|---|---|
| ☐ **Contraindicated** | ***Reason for contraindication*** | ***Immunizer Printed Name*** |
| | | ***Signature*** |

**Record of Immunization**

| ***Date/Time*** | ***Vaccine*** | ***Lot #*** | ***Dose*** | ***Route*** | ***Site*** | ***Immunizer Printed Name*** |
|---|---|---|---|---|---|---|
| | | | | **IM** | | ***Signature*** |
| | | | | **IM** | | ***Immunizer Printed Name*** |
| | | | | | | ***Signature*** |

This personal information is being collected under the authority of Section 61(c) of the *Access To Information and Protection of Privacy Act,* and will be used for determining eligibility to receive influenza immunization and monitor organizational uptake of the flu vaccine.