



Health Promotion Services
Influenza 2010 – Consent

Please complete and give to the nurse. Please print.

Name _____ Date of Birth: _____
(SURNAME) (GIVEN NAME)

QUESTIONS TO ANSWER	YES	NO
Have you had influenza immunization before? Approximately how many times?		
Are you allergic eggs or neomycin in Vaxigrip?		
Did you develop Guillain-Barré Syndrome (a serious, rare neurological disorder) within 8 weeks of receiving a flu injection? If yes, you are not allowed to get vaccinated.		

I have read the Health and Home Care Society of BC Seasonal Influenza (Flu) Fact Sheet. The nurse has reviewed the health questions with me. I had a chance to ask questions and I understand the risks and benefits of influenza immunization. With any vaccine or drug there is a very rare chance of an allergic response. Get medical help right away if it is hard to breath, you have hives or swelling of any part of your body.

Privacy: The Health and Home Care Society of BC complies with privacy legislation. Your personal information will only be shared for the purposes of emergency treatment or reporting of adverse reactions to the vaccine. **Acknowledgment and Waiver:** I waive any claim for damages that I (or anyone claiming on my behalf) may have against the Health and Home Care Society of BC and their directors, officers, employees and agents on account of injury or misfortune I may suffer as a result of this vaccination. I request to receive the influenza immunization.

Signature _____ Gender Male Female
Address: _____ City _____ Phone: _____
Doctor's name: _____
Date _____ Witness _____

Record of Vaccination: (To be completed by nurse):

Vaxigrip Vaccine Lot No: _____ Dose: _____
Time: _____ (24 hr clock) Injection Site: Left Deltoid Right Deltoid:

Adverse Event: Yes ___complete adverse event form No___

Signature of Nurse: _____ **Date:** _____