



# INFLUENZA VACCINATION – CONSENT FORM

FULL NAME:.....  
[PLEASE PRINT IN CAPITAL LETTERS]

COMPANY: .....SITE: .....

### General Information:

The flu is caused by a number of strains of the Influenza virus that are easily spread by infected droplets in the air through close personal contact, coughing and sneezing. The vaccination you will receive is designed to provide protection against several severe strains of the virus that the World Health Organisation has identified to be prevalent this year. It provides protection in up to 90% of people for approximately 9 months.

**BEFORE CONSENTING TO RECEIVING THE INFLUENZA VACCINATION, PLEASE ANSWER THE FOLLOWING QUESTIONS. THE INFORMATION YOU PROVIDE BELOW IS PRIVATE AND CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSE.**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you had the Flu Vaccination in previous years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever felt faint after an injection or had reaction to any vaccine or any other substance? <i>If YES, please specify</i> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you Allergic to anything (eggs, Iodine, Bee Stings, Sulphur Drugs, Penicillin)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you suffer from any diseases that weaken the immune system or are you having treatment that lowers immunity (radiotherapy or chemotherapy)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Women - Are you Breastfeeding, pregnant or planning to become so?<br><b>(Nurse will decline vaccination unless doctor certificate of approval is attached)</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any other vaccinations in the past month (e.g. Polio, Cholera)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have a severe cold or flu today?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you taking any medicines containing steroids? (e.g. Cortisone, Prednisolone)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you allergic to the antibiotic neomycin or to any other substance?<br><i>If YES, please describe</i> _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have any ongoing medical problems? (e.g. asthma, chest infections, diabetes, psoriasis, high blood pressure, stomach ulcer, joint problems, anxiety, depression or epilepsy)<br><i>If YES, please describe</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have a condition of the brain or spinal cord, or any other serious medical condition?<br><i>If YES, please describe</i> _____  | <input type="checkbox"/> | <input type="checkbox"/> |

I also understand and agree that:

- My consent to the vaccination is completely voluntary, and that this vaccination program is provided by my employer as a service to me;
- The information provided by me in this consent form is true and accurate;
- Medivax has no obligation to provide me with the vaccination, and administration or otherwise is at their discretion;
- Influenza vaccinations may cause symptoms which include a sore arm or mild fever, tiredness or muscle aches;
- I have been given an opportunity to read the medical information relating to the influenza vaccine and seek medical advice about its contents;
- To the extent permitted by law, Medivax disclaim all liability related to the vaccination including but not limited to negligence.

**I have read and understood the above information and the information sheet and consent to receiving an influenza vaccine injection.**

Signed.....Date.....

*Vaccinator use only*

Batch Number: (apply sticker) \_\_\_\_\_

Vaccinator's Name: \_\_\_\_\_