Advanced Medical Consultations

Influenza Vaccination Consent Form

Resident Information

Last Name:_____

First Name:_____ Date of Birth:_____

Screening for influenza vaccine eligibility

1. Do you have a severe allergy to eggs? ☐ Yes ☐No
2. Have you ever had a life-threatening reaction to the influenza vaccine? ☐Yes ☐No
3. Do you have a history of Guillain-Barre Syndrome? ☐Yes ☐ No
4. Are you moderately or severely ill today? ☐Yes ☐No

If yes to any questions 1-3 then DO NOT vaccinate with influenza vaccine. If yes to question 4, vaccinate when resident has recovered.

I have read or had explained to me the Vaccination Information Statement about influenza vaccination and I understand the benefits and risks of influenza vaccination. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request).

Signature: _____ Date:_____

Name (print or type):_____

Relationship to Resident: _____

To be completed by person administering vaccine

Today's Date:_____

Site of Injection: ☐R ☐L

Lot Number:_____ Expiration Date: _____

Administered by: _____

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