2020-2021 FLU VACCINE CONSENT FORM

Contact Information (Please print):

First Name: _____ **Last Name:** _____

Street Address: _____ **City/ Town:** _____ **Phone Number:** _____

Date of Birth: ____ ____ ____ (MM DD YYYY)

Sex:

- ○ Male
- ○ Female
- ○ I identify as (please specify): _____

Please answer the following questions.

	Yes	No
Is this your first time getting the flu vaccine?	○	○
Have you ever had, or do you currently have, Guillain-Barré Syndrome?	○	○
Have you ever had a serious allergic reaction to the flu vaccine?	○	○
Are you allergic to eggs, chicken, thimerosal, or formaldehyde?	○	○
Are you under 19 years of age and undergoing treatment with Aspirin (acetylsalicylic acid) for long periods?	○	○

The following questions are optional.

Some people are at higher risk of complications or hospitalization if they catch the flu. High-risk groups include:

- People younger than 5 or older than 65
- People who are pregnant
- Indigenous peoples
- Anyone who lives in a nursing home or long-term care facility
- People with the following conditions: heart, brain, lung, kidney or immune disorders, diabetes, cancer, morbid obesity or anemia

	Yes	No
Are you a member of a high-risk group?	○	○

Some people may have a higher chance of spreading the flu to people at high risk. These groups include:

- Healthcare workers
- People who care for children under 5 years of age
- People who live in the same household as people at high risk

	Yes	No
Do you belong to any of these groups?	○	○

Personal information is collected under the authority Section 5(2) of the Health Protection and Promotion Act. This information will be used for providing influenza vaccination services, the delivery of public health programs and services, and the administration of the agency, in compliance with legal and regulatory requirements.

Please acknowledge the following:

○ I have had the opportunity to read the flu vaccine information. I want to get the flu vaccine. After I get the vaccine, I understand that I must wait and be monitored at the clinic for 15 minutes.

Client Signature: _____ **Date:** ____ ____ ____
MM DD YYYY

Parent/Guardian Signature (if applicable): _____

FOR COMPLETION BY HEALTH CARE PROVIDERS

Vaccine Given:

- ○ FluLaval-Tetra (6 months +)
- ○ Fluzone Quad (6 months +)
- ○ Flucelvax Quad (9 years +)
- ○ High Dose Fluzone (65 years +)
- ○ Other: _____

Injection Site:

- ○ Deltoid – Right
- ○ Deltoid – Left
- ○ Anterolateral Thigh – Right
- ○ Anterolateral Thigh – Left

Lot Number: _____ **Expiry Date:** _____

Dosage:

- ○ 0.5 ml IM
- ○ Other

Health Care Provider: _____ **Date:** ____ ____ ____
MM DD YYYY

Time: _____

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