simcoe muskoka
DISTRICT HEALTH UNIT

Influenza - Consent for Immunization

Last/Family Name		First Name	
☐ Male ☐ Female	Date of Birth year / month / day	Home Phone ( )	Work Phone ( )
Address		City	Postal Code
Family Doctor's Name		Family Doctor's City	

Screening Questions	No	Yes	If "Yes", please describe
Have you received Seasonal Flu vaccine before?			
Are you allergic to any of the vaccine components?			
Do you have a fever?			
Do you have serious medical conditions?			
Do you have a history of seizures or fainting?			
Are you on any medication?			
Have you ever developed wheezing, difficulty breathing and/or chest tightness within 24 hours after receiving a flu vaccine?			
Have you experienced Guillain-Barre syndrome within 6 weeks of receiving a previous influenza vaccine?			

For the following two statements, if you agree please check the box provided beside each statement:

- ☐ I consent to have my influenza immunization information reported in aggregate (group) form to the Ministry of Health and Long Term Care for public health purposes
- ☐ I consent to have my influenza immunization information shared with my health care provider

I further confirm that I have read the Influenza Vaccine Fact Sheet provided and I understand the benefits, risks and possible reactions after vaccination. I have also had an opportunity to ask questions and have had them addressed to my satisfaction. I consent for the vaccine to be given. I have been advised to wait 15 minutes following injection to be observed for any potential adverse reactions.

Signature: _____ Date: _____

Nursing Interventions (√ to indicate completed):

- ☐ Fact sheet provided to the client or parent for review prior to immunization
- ☐ Reviewed the screening questions with the client
- ☐ Client given an opportunity to ask questions and questions were addressed
- ☐ After care sheet completed, reviewed and provided to the client

Vaccine	Vaccine Lot Number	Expiry Date	Dose	Route	Site	
Vaxigrip® Fluviral® Agriflu® Fluad®			mL	IM	Rt Lt	Arm Thigh

Date: _____ **Time:** _____ **Nurses Signature:** _____

PROGRESS NOTES

Date & Time	Narrative Notes

This information is collected under the authority of the *Health Protection and Promotion Act R.S.O 1990 c.H.7., s.4*. The personal health information collected on this form will be used to maintain immunization records and to monitor the use of vaccines for public health purposes. Questions regarding the collection and use of personal health information should be directed to the Office of the Privacy Officer, Simcoe Muskoka District Health Unit, 15 Sperling Drive, Barrie ON L4M 6K9, 705-721-7520 or 1-877-721-7520.