Influenza Vaccine Consent Form

Last Name:_____ First Name:_____

Date of Birth (dd/mm/yyyy)_____ Gender: _____

Phone Number:_____ Address: _____

Course:_____Provincial Health Card Number: _____

Have you had a serious reaction to the influenza vaccine in the past?	Y ☐	N ☐
Have been diagnosed with Guillian-Barre Syndrome?	Y ☐	N ☐
Do you take a blood thinner or have a bleeding disorder?	Y ☐	N ☐
Do you have a new or changing condition affecting the brain or nervous system?	Y ☐	N ☐
Are you pregnant?	Y ☐	N ☐
Are you allergic to the following?		
Egg protein	Y ☐	N ☐
Formaldehyde	Y ☐	N ☐
TritoX100	Y ☐	N ☐
Thimerosal	Y ☐	N ☐
Gentamicin	Y ☐	N ☐
Neomycin	Y ☐	N ☐
Kanamycin	Y ☐	N ☐

Acknowledgment and Waiver

I consent to receive the flu vaccine. I understand the possible side effects and risks.

I understand that I am responsible to wait around for 15 minutes after the immunization is given to observe for side effects.

Date:_____ Name:_____

This is your receipt of receiving the flu shot.

Name: Influenza Vaccine/ Lot number:

Signature: Date: