INFLUENZA Vaccine
Consent

CLIENT INFO

LAST NAME	FIRST NAME	GENDER o Male o Female o Other: _________

DOB YYYY/MM/DD	AGE	HEALTH CARD NUMBER	PHONE NUMBER

HOME ADDRESS	CITY	POSTAL CODE

CLIENT HEALTH HISTORY

Please answer the following health history questions. A nurse will review any "yes" responses.

Question		
1. Are you feeling ill today?	**YES**	**NO**
2. Have you received the flu vaccine in the past? a. **CHILDREN 6 MONTHS UP TO 9 YEARS OF AGE** i. If yes, Date of the first dose: YYYY/MM/DD	**YES**	**NO**
3. Have you ever had an allergic reaction to a vaccine in the past? (Including flu vaccine)	**YES**	**NO**
4. Do you have any allergies? **Check those that apply.** O Thimerosal O Polysorbate 80 O Triton X-100 O Sodium Deoxycholate O Formaldehyde O Other: ____________________	**YES**	**NO**
5. Are you allergic to eggs or chicken protein?	**YES**	**NO**
6. Do you have a history of Guillain-Barré syndrome or Oculo-Respiratory Syndrome?	**YES**	**NO**
7. History of fainting	**YES**	**NO**

CONSENT FOR IMMUNIZATION

I have read (or had explained to me) and I understand the Influenza Vaccine Information Sheet. I have had the opportunity to ask questions and to have them answered to my satisfaction. I hereby consent to having the influenza injection given to me by the Nurse of the Renfrew County and District Health Unit.

If you are signing for someone other than yourself, indicate your relationship to that person:	RELATION

PRINTED NAME	SIGNATURE	DATE (YYYY/MM/DD)

Personal information contained on this form is collected under the authority of one or more of the following (as amended): the Health Protection and Promotion Act, R.S.O. 1990; the Immunization of School Pupils Act, R.S.O. 1990; the Regulated Health Professions Act, 1991, S.O. 1991; and is in compliance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 and the Personal Health Information Protection Act, 2004, S.O. 2004. This information is used to ensure that all appropriate personal care and public health services are provided, and that necessary statistics are kept. Questions about this collection should be directed to the Program Manager at the Renfrew County and District Health Unit, 141 Lake St, Pembroke, ON K8A 5L8, 613-732-3629.

Renfrew County and District Health Unit
"Optimal Health for All in Renfrew County and District"

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FOR CLINIC USE ONLY						
☐ I have assessed the client's age.			CLIENT AGE		INITIALS	
≥ 65 years ONLY				QUADRIVALENT High-Dose Injectable Influenza		
VACCINE	DOSE	SITE	ROUTE	LOT # / EXPIRY	DATE & TIME	GIVEN BY
Fluzone® High-Dose (SP)	0.7mL	**Left** OR **Right** Deltoid	IM		YYYY/MM/DD	
≥ 65 years ONLY				TRIVALENT Adjuvanted Injectable Influenza		
VACCINE	DOSE	SITE	ROUTE	LOT # / EXPIRY	DATE & TIME	GIVEN BY
Fluad® Adjuvanted (SQ)	0.5mL	**Left** OR **Right** Deltoid	IM		YYYY/MM/DD	
≥ 6 months				QUADRIVALENT Injectable Influenza		
VACCINE	DOSE	SITE	ROUTE	LOT # / EXPIRY	DATE & TIME	GIVEN BY
Fluzone® Quadrivalent (SP)	0.5mL	**Left** OR **Right** ○ **Deltoid** ○**Vastus Lateralis**	IM		YYYY/MM/DD	
FluLaval (GSK)	0.5mL	**Left** OR **Right** ○ **Deltoid** ○**Vastus Lateralis**	IM		YYYY/MM/DD	
☐ **Entered in Panorama**						