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

INFLUENZA Vaccine
Consent

CLIENT INFO			
LAST NAME		**FIRST NAME**	
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.

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 Eggs or egg protein O Sodium Deoxycholate O Formaldehyde O Other: _____	**YES**	**NO**
5. Do you have a history of Guillain-Barré syndrome or Oculo-Respiratory Syndrome?	**YES**	**NO**
6. Do you have a 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.

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