

## Seasonal Influenza Consent

Location:			
Name:		Date of Birth:	
		Male <input type="checkbox"/> or Female <input type="checkbox"/>	
Phone:	Ontario Health Card #	Family Physician:	
Are you:			
A pregnant woman <input type="checkbox"/>	A child 6 to 24 months of age <input type="checkbox"/>	A health care worker <input type="checkbox"/>	A higher health risk (asthma, diabetes, heart disease, cancer, etc.) <input type="checkbox"/>
An emergency services worker (e.g., Ambulance, Fire, Police) <input type="checkbox"/>	Over 65 years of age <input type="checkbox"/>		
Are you in regular contact with someone:			
In the higher health risk category <input type="checkbox"/>	Over 65 years of age <input type="checkbox"/>	Under 24 months <input type="checkbox"/>	Who is pregnant <input type="checkbox"/>
Have you had any influenza shot before?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Do you have allergies? (If yes, please discuss with the nurse)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Have you ever reacted to a vaccine?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Do you have a fever today?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
<p>Information on the influenza vaccine has been explained to me. I understand that the vaccine can help to protect me from the influenza virus. I have had the chance to ask questions which were answered to my satisfaction.</p> <p><b>Parent/Guardian Consent:</b> I have read or had explained to me the information about the vaccine. I ask that the above named child be immunized against seasonal influenza.</p> <p>Parent/Guardian Signature: _____ Date: _____ Print Name: _____ (Parent or Guardian - please circle one)</p>			
<b>For nurses use only:</b>			
Vaccine 0.25 mL/0.5 mL administered intramuscularly.			
Lot#			
Right <input type="checkbox"/>	Left <input type="checkbox"/>		
Deltoid/V. Lateralis	Date:		
Signature of Nurse:			

# FREE SEASONAL INFLUENZA

## Immunization Clinics

### Health History for Seasonal Flu Vaccine

Do any of the following apply to you? Please review and inform Registration of your answers.

	YES	NO
1 Are you a first responder with the police? .....	<input type="checkbox"/>	<input type="checkbox"/>
2 Are you a firefighter? .....	<input type="checkbox"/>	<input type="checkbox"/>
3 Are you a poultry worker? .....	<input type="checkbox"/>	<input type="checkbox"/>
4 Do you have a cardiac or pulmonary disorder (including bronchopulmonary dysplasia, cystic fibrosis and asthma)? .....	<input type="checkbox"/>	<input type="checkbox"/>
5 Do you have diabetes mellitus or other metabolic diseases? .....	<input type="checkbox"/>	<input type="checkbox"/>
6 Do you have cancer, immunodeficiency, or immunosuppression (due to underlying disease and/or therapy)? .....	<input type="checkbox"/>	<input type="checkbox"/>
7 Do you have renal disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
8 Do you have anemia or hemoglobinopathy? .....	<input type="checkbox"/>	<input type="checkbox"/>
9 Are you a child or adolescent with conditions treated for long periods with acetylsalicylic acid? .....	<input type="checkbox"/>	<input type="checkbox"/>
10 Are you a pregnant woman? .....	<input type="checkbox"/>	<input type="checkbox"/>
11 Are you a household contact/caregiver to an infant less than 6 months old, or a household contact/caregiver to anyone who is immunocompromised? .....	<input type="checkbox"/>	<input type="checkbox"/>
12 Do you live/work/volunteer in a nursing/retirement home or school residence? .....	<input type="checkbox"/>	<input type="checkbox"/>
13 Are you a health care worker or emergency care worker? .....	<input type="checkbox"/>	<input type="checkbox"/>
14 Are you 65 years of age or older? .....	<input type="checkbox"/>	<input type="checkbox"/>
15 Have you ever developed red eyes and/or respiratory problems such as cough, wheeze, difficulty breathing, hoarseness, sore throat and/or facial swelling within 24 hours after receiving a flu vaccine? .....	<input type="checkbox"/>	<input type="checkbox"/>
16 Do you have any active/unstable neurological problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
17 Are you allergic to any of the following?		
a <input type="checkbox"/> Eggs and egg products .....	<input type="checkbox"/>	<input type="checkbox"/>
b <input type="checkbox"/> Thimerosal .....	<input type="checkbox"/>	<input type="checkbox"/>
c <input type="checkbox"/> Neomycin.....	<input type="checkbox"/>	<input type="checkbox"/>
d <input type="checkbox"/> Formaldehyde.....	<input type="checkbox"/>	<input type="checkbox"/>

In providing the information in this form, I consent to the collection of personal health information for the purpose of providing vaccine, maintaining records, and surveillance and evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_