INFLUENZA IMMUNISATION CONSENT FORM

PATIENT NAME: ________________________________ **APPOINTMENT TIME** _______________

DOB: ____/____/_____ CURRENT AGE: ________

PLEASE TICK BOXES BELOW **WHICH APPLY TO ABOVE PATIENT**

Condition	Tick	GOVERNMENT FUNDED
6 MONTHS TO 4 YEARS OLD		
65 OR MORE YEARS OLD		
PREGNANT		
ABORIGINAL OR TORRES STRAIT ISLANDER		
CARDIAC DISEASE Cyanotic congenital heart disease, Coronary artery disease, Congestive heart failure		
CHRONIC RESPIRATORY CONDITIONS Severe asthma (for which frequent medical treatment is required including the use of multiple medications) Suppurative lung disease, bronchiectasis, cystic fibrosis, Chronic obstructive pulmonary disease ,chronic emphysema		
CHRONIC NEUROLOGICAL CONDITIONS Hereditary and degenerative CNS diseases, Seizure disorders, Spinal cord injuries, Neuromuscular disorders, conditions which increase respiratory infection risk.		
IMMUNOCOMPROMISING CONDITIONS HIV infection, malignancy, immunocompromise due to disease or treatment, asplenia or splenic dysfunction, solid organ transplant, haematopoietic stem cell transplant, CAR T-cell therapy.		
CHRONIC METABOLIC DISORDERS Type 1 OR 2 diabetes, amino ac		
CHRONIC KIDNEY DISEASE Chronic kidney disease stage 4 or 5		
HAEMATOLOGICAL DISORDERS Haemoglobinopathies		
LONG-TERM ASPIRIN THERAPY IN CHILDREN AGED 6 MONTHS TO 10 YEARS		
FUNCTIONAL OR ANATOMICAL ASPLENIA Sickle Cell disease or other haemoglobinopathies. Congenital or acquired asplenia (eg splenectomy) or hyposplenia		
NONE OF THE ABOVE - PRIVATE VACCINE $25 (funded by Qld Gov if resident)		

BEFORE RECEIVING THE VACCINE, we need you to answer the following questions. The information you provide is private and confidential. It will not be used for other purposes.

Do you have a needle phobia? ***If yes this patient is not suitable to be booked into a flu clinic*** yes ( ) no ( )

Have you had a flu vaccine before? ___________________________________ yes ( ) no ( )

Have you had any serious problems after flu vaccine? ____________________ yes ( ) no ( )

Have you ever felt faint or fainted after immunisations.? ________________ yes ( ) no ( )

Are you currently suffering a feverish illness? __________________________ yes ( ) no ( )

Are you allergic to eggs or chicken feathers? ____________________________ yes ( ) no ( )

Are you allergic to Neomycin, Polymixin, Gentamycin Thiomersol or Latex? ____ yes ( ) no ( )

Are you taking any medications now (especially Cortisone, Steroids, Immunosuppressive medication, or blood thinners)?_____________________________________ yes ( ) no ( )

IMPORTANT

ABOUT THE FLU VACCINE

Flu vaccine has been shown to be very effective at preventing influenza.

Flu vaccine cannot give you flu.

Flu vaccine is given in the arm and takes 2 weeks to be fully protective.

Discomfort, redness and swelling at the injection site is the most common side effect.

Very occasionally fever, tenderness in the muscles and tiredness may occur within a few hours of vaccination and may last 1-2 days.

Rarely-Immediate adverse events (mostly probably due to eggs) such as Hives, Angioedema, Asthma or systemic anaphylaxis are a rare consequence.

Guillain–Barré Syndrome has been rarely implicated with influenza vaccination (1 in 2 million) although direct causative relationship has not been established.

Flu vaccine does not prevent common cold.

Most people have no significant problems from the vaccine.

ABOUT INFLUENZA

Influenza can be a serious disease with significant complications and restriction of day to day activities

Symptoms of influenza include the sudden onset of fever, muscle pain, sore throat, dry cough, headache and tiredness which may persist for several weeks.

I have read and understand this 2-page information form and consent to receiving influenza vaccination.

Signature: - _______________________________

PRINT NAME _______________________________ DATE: ____/____/2025

(Patient/Parent/Guardian)

PLEASE WAIT FOR 10 MINUTES AFTER YOUR VACCINATION

Office use only:

Vaccine administered by: ____

Site: Left Arm Deltoid ☐ Right Arm Deltoid ☐ Left Thigh ☐ Right Thigh ☐

Vaccine Label:

Entered into Medical Director by: _________________________________