Influenza vaccination consent form

Patient/Guardian

Surname: _____ First name: _____

Phone: _____ Date of birth: _____ Gender: M F NHI: _____

Ethnicity: ◯ NZ European ◯ Māori ◯ Samoan ◯ Cook Island Māori ◯ Tongan ◯ Niuean ◯ Chinese ◯ Indian ◯ Other (such as Dutch, Japanese, Tokelauan) Please state: _____

Name of guardian (if applicable): _____

Address: _____

Your doctor's name / surgery address: _____

This form confirms that you have given your consent to have an influenza vaccination.
If any of the following apply to you then please advise your healthcare professional:

◯ I am currently unwell with a high fever ◯ I have had a previous severe response to an influenza vaccination

◯ I have a history of a bleeding disorder ◯ I have received treatment for cancer during the last 12 months

Possible responses to influenza vaccination:

Influenza vaccination is usually well tolerated. Possible responses include pain, redness and/or swelling at the injection site for a day or two; a mild fever, muscle aches or headache within the first two days. Rarely, an allergic response can occur.

You should remain under observation to watch for an allergic response for 20 minutes after your vaccination.

The influenza vaccine does not protect against other respiratory viruses such as the common cold. For more information on the influenza vaccine please refer to the consumer medicine information sheet located at **www.medsafe.govt.nz.**

The Ministry of Health keeps a record of influenza vaccinations on the National Immunisation Register so that authorised health professionals can find out what vaccinations have been given. It helps to monitor the population's protection against influenza. If you do not want your vaccination recorded on the National Immunisation Register please advise your doctor, nurse or healthcare professional.

I have read or have had explained to me information about influenza vaccination, and I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccination. I understand getting the vaccination is my choice. I agree to get the vaccination and that it is recommended that I wait here for 20 minutes after my vaccination.

I consent to this information being given to my healthcare provider to update applicable records.

Signed: _____ Date: _____

Signed/Guardian (if applicable): _____

Relationship to the child/patient: _____

Vaccination record (clinical use only)

Vaccine: _____ Administered: Left / right arm

Vaccine batch number: _____ Expiry date: _____

Vaccinator: _____

The influenza vaccine is a prescription medicine. Talk to your healthcare professional about the benefits and possible risks.