PATIENT CONSENT FORM - INFLUENZA VACCINATION 2021

6 mnths – 4 yrs

Surname: _____ First Name: _____

DOB: _____ NHI: _____

Ethnicity (Please circle): NZ Euro Maori Samoan Indian Chinese Cook Island Other

Name of Guardian (If Applicable): _____

If not registered at Ropata,
your Medical Centre: _____

This form confirms that you have given your consent to have an influenza vaccination.

1. If any of the following apply to you please tick as appropriate and inform those vaccinating you:

- I am currently unwell with fever ☐
- I have a history of a bleeding disorder ☐
- I have already received the flu vaccination for the 2021 flu season ☐
- I have undergone bone marrow transplant in last year ☐
- I have previously had a severe reaction to the flu vaccine ☐
- I have an **allergy to Neomycin, Kanamycin, Polymyxin B, Gentamicin, Chicken Protein, Latex** ☐
- I have had a **Covid-19 vaccine** in the past 2 weeks or am expecting to have one in the next 2 weeks ☐

2. None of the above conditions apply to me ☐

3. I understand I need to remain under observation to monitor for a severe allergic reaction for a maximum of 20 minutes after my vaccination. The nurse/doctor will advise how long. ☐

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.

The influenza vaccine does not protect against other respiratory viruses such as the common cold.

*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 you vaccinator.*

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 after my vaccination for a period advised to me by the nurse/doctor.

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

Signed: _____ *Date:* _____

Guardian: _____ *Relationship to patient:* _____

FOR NURSE AND ADMINISTRATION USE ONLY

Eligible for funded vaccination: **YES** **NO**

65 yrs + Pregnant Diabetes Chronic Renal Disease Cancer

Auto Immune Disease Immune suppression or HIV Transplant Recipient Bleeding Disorder

Cochlear implant Pre or post Splenectomy Down Syndrome

Child 4yrs > hospitalised for respiratory illness

Cardiovascular Disease: Ischaemic Heart Disease Rheumatic Heart Disease Congestive Heart Failure

Congenital Heart Disease Cerebrovascular Disease

Chronic Respiratory Disease: Asthma (with regular preventative therapy)

Other Chronic Respiratory disease with impaired lung function

Vaccination Record:

Given under standing order: Influenza Vaccine 2021

PLACE VACCINE STICKER HERE or

Vaccine Batch Number: _____

Expiry Date: _____

Administered: LEFT ARM RIGHT ARM

VACCINATOR: _____