Newfoundland Labrador

HCN: _____

Province/Territory: _____ Expiry: _____

Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F ☐ UN

Mailing Address: _____

City: _____

Province/Territory: _____ Postal Code: _____

Telephone: (Indicate Preferred) ☐ Home _____

☐ Cell _____ ☐ Work _____

Seasonal Influenza Immunization Consent And Record of Immunization Form

☒ Eastern Health ☐ Central Health ☐ Western Health ☐ Labrador-Grenfell Health

Age Group: ☐ 6 months - 4 years* ☐ 5 - 8 years* ☐ 9 -19 years ☐ 20 - 44 years ☐ 45 - 64 years ☐ 65+ years

***Children 6 months to less than 9 years of age receiving influenza vaccine for the first time are recommended to receive two doses of vaccine spaced at least four weeks apart.**

Screening Questions	Check All Appropriate Boxes		
	Yes	No	Unsure
If your child is less than 9 years of age, are they receiving the flu shot for the first time?* (see statement above in bold)	☐	☐	☐
Do you or your child have a history of allergies? (medications, vaccine, eggs, food). If yes, please list:	☐	☐	☐
Are you pregnant?	☐	☐	☐
Do you or your child have any past or present medical conditions? If yes, please describe:	☐	☐	☐
Have you or your child ever had a reaction to a flu shot?(red eyes, hives, rash, or difficulty breathing). If yes, please describe:	☐	☐	☐

Adverse Reactions

1. Common side effects with injection are soreness and redness at the injection site that may last up to 2 days.
2. Less frequent side effects include headache, muscular aches/pains, red eyes, cough, irritability and sore throat.
3. Allergic reactions such as breathing problems and hives are very rare and may occur with extreme sensitivity to certain components of the vaccine.

CONSENT

I understand the information regarding the benefits and risks of the seasonal influenza vaccine provided by the Health Care Provider.

I **CONSENT** for me or my dependent to have the seasonal influenza vaccine, two (2) doses for children under age nine (9) years with no prior seasonal influenza vaccine.

I CONSENT to the Health Care Provider disclosing my or my dependent's personal information and personal health information to the Newfoundland and Labrador Centre for Health Information to be added to my or my dependent's electronic health profile.

Signature: _____

Relationship to child/person: _____

Date: _____

To be completed by Health Care Provider administering influenza vaccine

	Reason for contraindication	*Immunizer's Printed Name*
☐ Contraindicated		*Signature*

Record of Immunization

Date/Time	*Vaccine*	*Lot Number*	Dose	Route	Site	*Immunizer's Printed Name* / Signature
			0.5mL	Intramuscular		
			0.5mL	Intramuscular		**Immunizer's Printed Name** / **Signature**

Depot: _____ Program: _____ Site vaccine housed: _____ Location: _____

This personal health information is being collected and used under the authority of s. 29 and s.34(a)(m) of the Personal Health Information Act, and will be used for determining eligibility to receive influenza immunization and monitor organizational uptake of the flu vaccine. If you have concerns about the collection, use or disclosure of your personal health information, please contact the privacy office of your organization.