Seasonal Influenza Vaccine Consent Form 2020-2021

Fleming College

Last Name: _____ First Name: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Email: _____

Birthdate (Year/Month/Day): _____

Health Card #: _____ Version Code (letters after #) _____

Morcare Client ID# (international students only)_____

Have you received the seasonal flu vaccine in the past? ☐No ☐Yes→date (YYYY/MM/DD): _____ ☐ Unsure

1. Do you have a fever or are you currently feeling unwell? ☐No ☐Yes→describe: _____
2. Have you experienced an adverse reaction to previous influenza vaccinations? ☐No ☐Yes→describe: _____
3. If you are taking oral theophylline, oral blood thinners or medications that weaken the immune system or if you are immunocompromised, is your health care provider aware you are receiving the flu vaccine? ☐Yes ☐ No
4. Have you ever had Guillain Barré Syndrome diagnosed within 6 weeks after receiving the influenza vaccine? ☐No ☐Yes→Do not receive the vaccine
5. Do you have an active, unstable neurological condition? ☐No ☐Yes→postpone vaccine until stable
6. Have you ever had Oculo-Respiratory Syndrome (ORS) (cough, wheeze, difficulty breathing, hoarseness, sore throat and/or facial swelling) within 24 hours after receiving the influenza vaccine with severe respiratory symptoms? ☐No ☐Yes→discuss with health care provider
7. Do you fit into one of these high risk categories for contracting influenza or transmitting influenza: ☐No ☐Yes
   - 65 years old or older
   - health care worker and other care providers in facilities & community settings.
   - provide essential community services (fire, police, ambulance)
   - poultry worker
   - members of a household expecting a newborn during the influenza season
   - household contact/caregiver to an infant less than 6 months old or to anyone at high risk for influenza related complications
   - provide regular child care to children who are up to 5 years of age
   - have a chronic condition (cardiac, kidney, blood or pulmonary), a condition that compromises the management of respiratory secretions and are associated with an increased risk of aspiration, a condition that compromises the immune system (e.g. cancer, HIV, diabetes, metabolic diseases), or morbid obesity (body mass index greater or equal to 40)
   - resident of a nursing home or chronic care facility
   - child or adolescent with a condition treated with acetylsalicylic acid (ASA)
   - pregnant
   - healthy children up to 5 years of age
   - provide services in closed or relatively closed settings (i.e. crew on a ship) to persons in one of the above categories
8. Are you allergic to the following: Neomycin: ☐No ☐Yes Formaldehyde: ☐No ☐Yes
   Kanamycin: ☐No ☐Yes Thimerosal: ☐No ☐Yes

I confirm that I have read the information on the influenza vaccine and understand the benefits and possible risks of the vaccine. Any questions I had were answered to my satisfaction. I have been advised to wait 15 minutes following injection to be observed for potential adverse reactions. I am providing consent for myself (the above-named) to be vaccinated against influenza.

Name of person completing form if different from above: _____

Relationship to above: _____

Signature of client/parent/guardian:_____ Date: _____/_____/_____
yyyy mm dd

If signing for someone other than yourself, you must be the legal substitute decision maker/legal guardian

Contact in case of emergency: _____ Phone: _____

Notice of Collection: Personal information is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, to maintain a record of your immunization and to provide statistics required by the Peterborough County-City Health Unit and the Ministry of Health and Long-Term Care. Should you have questions about the collection and maintenance of this information, please contact Dr. Rosana Pellizzari at 705-743-1000 ext. 264.

For Vaccinator's Use Only When Electronic Clinic Management Is Not Used

Are you feeling ill today? fever? infection? No ☐ Yes ☐→describe_____
Have you ever had a flu shot before? No ☐ Yes ☐→describe problems, if any_____
Have you ever had an allergic reaction to a vaccine? No ☐ Yes ☐→describe_____
Do you have a blood disorder or are you taking medication that could affect blood clotting? No ☐ Yes ☐ →describe: _____
Did you read the information provided to you? No ☐ Yes ☐

Vaccine: ☑ Fluzone **Lot #:** _____ Expiry: _____

Site: ☐deltoid ☐quad ☐right ☐left **Dose:** 0.5 ml **Date (YYYY/MM/DD):** _____ **Time:** _____ hrs.

Vaccinator Signature: _____ Info. Form Reviewed by Patient ☐No ☐Yes