

# INFLUENZA VACCINATION CONSENT FORM – 2012

**Please read the following information before completing this form and receiving the vaccine.**

**NOTE:** It is advised that you remain in the vicinity (hospital/clinic) for 15 minutes after the vaccination.

**Adverse Reactions** – The vaccine is usually well tolerated apart from occasional soreness at the injection site. A mild fever, tiredness or muscle aches may occur within 6-12 hours and lasting 1-2 days. **It cannot give you a dose of the 'Flu'.**

More severe adverse events such as hives and anaphylactic reactions are rare.

**You should *NOT* have the vaccine if:**

- 1. You have a hypersensitivity (allergy) to eggs.** *This would include swelling of the lips or tongue or respiratory distress upon the ingestion of eggs, or sensitivity to chicken feathers.*
- 2. You have a sensitivity to any of the product components.** *(Beta-propiolactone, formaldehyde, thiomersal).*
- 3. You are allergic to the antibiotics neomycin or polymyxin.**
- 4. You have an illness with a temperature (fever over 38.5°C).** *Minor illness with/without fever does not contraindicate vaccination.*
- 5. You have a history of Guillain-Barre Syndrome with previous influenza vaccination related onset.**

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**I have read and understand the above information and consent to receiving the influenza vaccine.**

Name \_\_\_\_\_ Signature \_\_\_\_\_  
*(please print)*

Employee Number \_\_\_\_\_

Department/Ward \_\_\_\_\_ Campus \_\_\_\_\_

Occupational Group (✓ appropriate box)

**1. Clinical (Patient Contact) Staff**

- a. Medical Staff
- b. Nursing Staff
- c. Allied Health Staff
- d. Laboratory Staff
- e. Other Staff

**2. Non Clinical Staff**

Do you work in the Emergency Department? (✓ appropriate box)    **Yes**     **No**

## **OFFICE USE ONLY**

Date \_\_\_/\_\_\_/\_\_\_ Batch \_\_\_\_\_ Given by \_\_\_\_\_