Access Alliance
Multicultural Health and Community Services

Influenza Vaccination Screening and Consent Record 2018

Last Name: _____ **First Name**: _____ Age: ____ Gender: M/F

Date of Birth: _____ **Interpreter**: Yes/No **Language**: _____
dd/mm/yyyy

Access Alliance Client: YES/ NO **Client Chart #**_____**HIN**: _____

Address: _____ Phone: _____

Screening Questions

1. Are you a patient of Access Alliance? **Yes/No**
2. Do you have a fever or flu-like like symptoms now? **Yes/No**
3. Are you allergic to eggs/eggs products? **Yes/No**
4. Do you have any known allergies? **Yes/No**
5. Did you have a serious reaction to a previous flu/H1N1 vaccine? **Yes/No**
6. Do you have an active neurological disorder or a past history of Guillian-Barre Syndrome? **Yes/No**
7. **For Age <9,** are you previously vaccinated with a flu/H1N1 vaccine **Yes/No**

If No to question #7, for clinical patients RTC in 4 weeks for the 2nd dose Date: _____

For non- clinical patients, please go to your family doctor or TPH for the 2nd dose

Consent Record

Risks and benefits of receiving the influenza vaccine have been explained to me. There is opportunity to ask questions which have been answered to my satisfaction. I authorize the clinical staff of Access Alliance to administer the influenza vaccine to me. I am aware that I must wait for 15 minutes after the injection, and should report any unusual side effects to the clinical staff.

Patient (Guardian) Signature _____ Date: _____

Interpreted by: _____ Date:

Medication: FluLaval **Lot: PD29M** **Exp.: Jul 31, 2019**

Site: R / L deltoid / thigh I.M. Date:

Clinical staff signature: _____