Newfoundland Labrador

This form can be printed as a paper copy

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 _____

Employee Seasonal Influenza Immunization Consent Form

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

Employee ID: _____ Department Program: _____

Facility/Worksite: _____ Position/Job Title: _____

Employment Type:

☐ Contracted Physician ☐ Medical Residents/Interns/Clerks ☐ RHA Employee ☐ Student/Volunteer/Other

Age Group: ☐ < 20 years ☐ 20 - 44 years ☐ 45 - 64 years ☐ 65+ years

Screening Questions	Check All Appropriate Boxes		
	Yes	No	Unsure
Are you sick or do you have a fever today?	☐	☐	☐
Do you have any past or present medical conditions? If yes, please describe:	☐	☐	☐
Are you pregnant?	☐	☐	☐
Do you have a history of allergies? (medications, vaccine, eggs, food?). If yes, please list:	☐	☐	☐
Have you ever had the flu shot before?	☐	☐	☐
Have you 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** to have the seasonal influenza vaccine

Signature: _____

Date: _____

☐ Refusal

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

I **REFUSE** to have the seasonal influenza vaccine

Signature: _____

Date: _____

To be completed by Health Care Provider administering influenza vaccine

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

Record of Immunization

Facility/Clinic where vaccine administered:

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