

PARK ROAD SURGERY – CONSENT FOR Seasonal Influenza vaccine 2020/2021

Patient Name _____ Date of Birth _____

Contact telephone or email _____

Before seeing the Nurse/Pharmacist or Dr, please answer yes/no to the following questions and sign and date this form. Please bring the form with you and hand it in at your appointment.

1. Have you had a temperature in the last 24 hours Yes / no
2. Have you had a severe reaction to this vaccine or any other vaccine in the past ?
Yes / no
3. Are you currently taking high dose steroids (40mgs or more) Yes / no
4. Are you immunosuppressed or had immunosuppressive treatment in the last 6 months?
Yes/No
5. Are you allergic to any of the following
Eggs or egg products
Neomycin or Gentamicin
Formaldehyde, Benzonase or Sodium Deoxycholate ? Yes / no
6. Please state your ethnicity _____

I consent that I am well today and have been invited by the surgery to attend this clinic. I understand that at the appointment I will have the opportunity to discuss the vaccine and any potential side effects, including asking any questions that I may have.

Signed _____ Date _____

Official use

Date seasonal influenza 2020/21 IM vaccine given :

Left arm / Right arm

Batch :

Expiry :

Given by (initials) :

Record updated (initials):