CONSENT FORM FOR INFLUENZA VACCINATION

First name: …… Surname ……

Date of birth: ……..…. Medicare No. _ _ _ _ _ _ _ _ _ _

You reference number on the card (located on the left side, next to your name) ___

Street Address: ……...

Suburb: …… Post Code: ……

Contact Phone: Home ……..……Mobile: ……..…

Organisation / Employer……

NOTE: ON YOUR APPOINTMENT DAY, DO NOT ATTEND THE CLINIC IF:

- **YOU HAVE RETURNED FROM OVERSEAS TRAVEL IN THE LAST 14 DAYS**
- **HAVE HAD CLOSE CONTACT WITH A CONFIRMED CASE OF CORONAVIRUS**
- **HAVE A TEMPERATURE ABOVE 37.5 OR A COUGH, SORE THROAT OR SHORTNESS OF BREATH**

Before agreeing to receive the flu vaccine, you are required to:

- Take time to answer the following questions.
- If you have any questions, talk to your own doctor or the nurse administering your vaccine. The information you provide is private and confidential and will not be used for any other purpose.
- If you have any major medical conditions, please discuss and obtain advice from your treating doctor.
- Influenza vaccination is recommended for pregnant women and is safe to administer during any stage of pregnancy or while breastfeeding.

	YES	NO
Have you ever received a flu vaccine?		
Did you experience any significant problems after receiving a flu vaccine?		
Have you experienced a severe allergic or anaphylactic reaction to anything in the past?		
Are you taking any of the following medications? *(Please tick)* ☐ Warfarin (used to prevent blood clots) ☐ Medicines which lower the immune system such as cortisone or steroids or other medicines used to treat cancer		
Have you ever suffered from Guillain-Barre Syndrome?		

After your flu shot:

- You are required to wait on-site for 15 minutes after your vaccination
- Like all medicines, vaccines may have side-effects. These are usually very mild. Some individuals may develop a mild fever and muscle pains within 48 hours post vaccination. Some redness, tenderness, discomfort or swelling is common at the injection site, but this usually settles within a few days. (For more information please refer to the Consumer Medical Information)

The personal information requested on this form is being collected by Warrnambool City Council for the purpose of recording your vaccination history. Warrnambool City Council is committed to protecting the privacy, confidentiality and security of personal information, in accordance with the *Privacy and Data Protection Act 2014* and the *Health Records Act 2001*. The personal information you provide on this form and the vaccine you receive today will be notified to the Australian Immunisation Register. It will not be disclosed to any other external party without your consent, unless required or authorised by law.

I have read and understand this information provided to me and I consent to receiving a flu vaccine injection.

SIGNATURE……DATE……..

OFFICE USE ONLY:

RECEIPT NUMBER……

ADMINISTERD BY……**DATE**…….....