

Consent for Seasonal Influenza

September 2015

Please Print Clearly

Last Name: _____ First Name: _____
Date of Birth: _____ Age: _____ Male Female
Address: _____
Town/City: _____ Postal Code: _____
Phone: _____ Doctor: _____
Allergies: _____
Health Concerns: _____

I have read or had explained to me information about the Influenza Vaccine. I have had the chance to ask questions, which were answered to my satisfaction.

I agree to be vaccinated against influenza, or I agree as the parent/legal guardian of the individual named in this form that this individual be vaccinated against influenza.

I understand that as the person receiving influenza vaccine (I/the individual), must wait 15 minutes following the injection.

Signature Date

If you have any questions regarding this form or the Influenza vaccine, please call the Haldimand-Norfolk Health Unit at 519-426-6170 or 905-318-6623.

THIS SECTION TO BE COMPLETED BY HEALTH UNIT STAFF

Vaccine Given: _____ Dosage: _____ Route: _____ Site: _____
Lot #: _____ Children < 9 years of age: 1st vaccine 2nd vaccine Previous Vaccination

Date Time Nurses Signature

