Patient Registration & Consent Form

Wahroonga Family Medical FLU Consent 2021

Title: *(Please circle)*	**Mr**	**Mrs**	**Ms**	**Miss**	**Mstr**	**Dr**	**Prof**
Surname:					
First Name:				**Middle Name:** *(if applicable)*	
Date of Birth:	Day:	Month:	Year:	**Phone No.:**	
Mobile Phone:				**Work Phone:**	
Street Address:					
Suburb:				**State:**	**Postcode:**
Email Address:					
Medicare Card Number:				**Ref:**	**Exp Date:**
Pension or Health Care Card Number:					**Exp: Date**
Emergency Contact Name:		**Phone Number:**		**Relationship:**	

Pre: Vaccination Questions:	**YES**	**NO**
Are you 65 years or over		
Do you understand a Covid-19 vaccination should not occur 14 days before OR after your flu vaccination?		
Do you have Asthma or a chronic respiratory condition?		
Are you on a GP Care Plan?		
Are you Aboriginal or Torres Strait Islander		
Do you have any medication allergies? If yes please list:		
Do you have an acute feverish illness at present?:		
Have you been vaccinated against the flu in previous years?:		
Have you experienced any significant problems after any vaccinations?		
Are you allergic to eggs or chicken feathers?:	.	
Are you allergic to neomycin, or latex? (If yes cannot receive FLUARIX)		
Are you taking any cortisone, steroid, immunosuppressive medication or Theophylline, Warfarin or Dilantin? (If yes, please circle)		
WOMEN ONLY: Are you pregnant or breastfeeding?		

POSSIBLE ADVERSE EVENTS, PRECAUTIONS & MORE INFORMATION

- The influenza vaccine is generally well tolerated;
- Occasional discomfort, redness and swelling at the injection site is the most common adverse reaction;
- Fever, muscle pain and malaise occur infrequently within a few hours of vaccination and may last 1-2 days;
- Immediate adverse events such as hives, swelling of the face, lips or tongue, breathing difficulties, or systemic anaphylaxis are a rare consequence;
- Guillain-Barre Syndrome is rarely associated with influenza vaccination. 1 person in one million is thought to be affected, although a direct relationship has not been established;

I _____ *(print your name)***, have read and understood the above information and consent to receiving the influenza injection today. I confirm the above is correct and any issues will be discussed with the Nurse attending.**

Signature of Patient: _____ Date:_____

Office Use Only:	Date Given:	Brand Name: **FLUQUADRI VACCINE**
	Company:	Batch No.: