Masterton Medical - PATIENT CONSENT FORM

Patient/Guardian

Surname: First Name:
Date of Birth: M / F:
Address: Phone:

Your doctor's name:

This form confirms that you have given your consent to have the influenza vaccine for our records.
Young people aged 16 and above can consent to vaccination.

Does any of the following eligible criteria for a free vaccine apply to you? If yes, please tick

O Pregnancy
O Age 65 years or older (for Afluria Quad only, not the Fluad Quad)
O Cardiovascular (heart) disease
O Chronic respiratory (lung) disease (including asthma if on regular preventive treatment)
O Diabetes
O Chronic renal (kidney) disease
O Cancer (patient currently has cancer), excluding basal and squamous skin cancers if not invasive
O Other (please specify) ____

If any of the following apply to you then please consult your healthcare professional:

O I am currently unwell with a high fever
O I have had a previous severe reaction to an influenza vaccine
O I have a history of a bleeding disorder
O I have received treatment for cancer during the last 12 months

Possible reactions to influenza immunisation:
Influenza immunisation is usually well tolerated. Possible reactions include redness, tenderness or a hardness at the injection site for a day or two; a mild fever, muscle ache or headache within the first two days. Rarely, an allergic reaction can occur.

You should remain under observation to watch for allergic reactions for 20 minutes after your immunisation.
Influenza immunisation is highly effective but cannot guarantee complete protection against catching influenza. Influenza vaccine does not protect against other respiratory viruses such as the common cold.

The Ministry of Health keeps a record of influenza immunisation on the National Immunisation Register so that authorised health professionals can find out what immunisations have been given. It helps them identify people who are due for immunisation or who have missed out. Talk to your GP or health professional for more information about privacy. If you do not want your immunisation recorded on the National Immunisation Register please advise your doctor or healthcare professional.

I have read or have had explained to me information about influenza vaccine, and I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccination.
I understand getting the vaccine is my choice. I agree to get the vaccine and that it is recommended that I wait here for 20 minutes after my vaccination.
I consent to this information being given to my healthcare provider to update applicable records.

Signed:____ Date:

Signed/Guardian (if applicable):____

Relationship to the child/patient:____

Immunisation Record (for Clinic Use Only)
Vaccine:
Vaccine Batch Number:
Expiry Date:
Administered: Left/Right Arm
Vaccinator:

The influenza vaccine is a Prescription Medicine. Talk to your healthcare professional about the benefits and possible risks.