

CONSENT FOR INFLUENZA VACCINATION

IMPORTANT: Please read the immunisation information provided before completing this consent form.

	YES	NO
Are you well today?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been vaccinated against influenza this year?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced a severe reaction after any vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have ANY allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any medical conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Do you identify as Aboriginal or Torres Strait Islander?	<input type="checkbox"/>	<input type="checkbox"/>
It is recommended not to drive for 30 minutes following vaccination, please acknowledge	<input type="checkbox"/>	<input type="checkbox"/>

Name of person to be immunised: _____

Address: _____ Postcode: _____

Date of birth: _____ Age: _____ Phone: _____

Email address: _____

Medicare number: _____ Reference no next to name: _____

Consent for Vaccination

I have read and understood the information given to me about immunisation including the risks and benefits. I have been given the opportunity to discuss this with my nurse. I consent for the above named to be vaccinated with the 2023 Influenza Vaccine. I understand the information I provide, and information related to any vaccines administered, will be recorded electronically and/or in hard copy. I consent to the disclosure of this information to SA Health and local government councils (and their immunisation service providers) and to the Australian Immunisation Register. I can contact my immunisation service provider if I am concerned personal information has been misused or subject to unauthorised access.

If the issue remains unresolved, contact SA Health on 1300 232 272.

YES, I have read and understood the information given to me about immunisation including the risk of the vaccination and the risk of not being vaccinated. **I request to be vaccinated with the influenza vaccine.**

Signed: _____ Date: _____

Office use only:

Flu Vaccine Batch: _____ Time: _____ LA / RA

Given by: _____ Signature: _____

Date of Encounter: _____

NIP (free flu vaccine) / Worksite \$25 / CHB staff / \$22 to be paid at clinic or invoiced