

Influenza Consent Arepanrix™ H1N1

Location:			
Name:		Date of Birth:	Male <input type="checkbox"/> or Female <input type="checkbox"/>
Phone:	Ontario Health Card #		

Are you:

A pregnant woman <input type="checkbox"/>	A child 6 to 24 months of age <input type="checkbox"/>	A health care worker <input type="checkbox"/>	A higher health risk (asthma, diabetes, heart disease, cancer, etc.) <input type="checkbox"/>
An emergency services worker (e.g., Ambulance, Fire, Police) <input type="checkbox"/>	Over 65 years of age <input type="checkbox"/>		

Are you in regular contact with someone:

In the higher health risk category <input type="checkbox"/>	Over 65 years of age <input type="checkbox"/>	Under 24 months <input type="checkbox"/>	Who is pregnant <input type="checkbox"/>
Have you had any influenza shot before?		No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you have allergies? (If yes, please discuss with the nurse)		No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you ever reacted to a vaccine?		No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you have a fever today?		No <input type="checkbox"/>	Yes <input type="checkbox"/>

Information on the influenza vaccine has been explained to me. I understand that the vaccine can help to protect me from the influenza virus. I have had the chance to ask questions which were answered to my satisfaction. I understand that the most common side effects to the influenza immunization are minor and that the risk of a vaccine causing serious harm is extremely small.

Please sign when you see the immunization nurse.
I hereby consent to have the influenza immunization given to me by the KFL&A Public Health nurse.

Signature: _____

For nurses use only:

Vaccine 0.25 mL/0.5 mL administered intramuscularly.	
Lot#	
Right <input type="checkbox"/>	Left <input type="checkbox"/>
Deltoid/V. Lateralis	Date:
Signature of Nurse:	

Name: _____

Immunization date: _____

Return date: Next Fall/One month _____

Vaccine administered: Arepanrix™ H1N1

KFL&A PUBLIC HEALTH FREE H1N1 INFLUENZA IMMUNIZATION CLINICS

HEALTH HISTORY

Do you have any of the following? (Check all that apply)

	Yes	No
Do you have a fever?	<input type="checkbox"/>	<input type="checkbox"/>
Have you received the 2009 Seasonal Flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Are you from a remote community (350km or more from access to any medical care)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a health care worker involved in the pandemic response or delivering essential health care services (includes full-time, part-time, students and volunteers)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acute Care <input type="checkbox"/> Laboratory <input type="checkbox"/> Chronic Care <input type="checkbox"/> Public Health <input type="checkbox"/> Ambulatory/Community Care <input type="checkbox"/> Pharmacies <input type="checkbox"/> Emergency Medical Services <input type="checkbox"/> Vaccine Manufacturers		
Are you a first responder with the police?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a firefighter?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a swine worker?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a poultry worker?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a chronic condition?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Do you have a cardiac or pulmonary disorder (including bronchopulmonary dysplasia, cystic fibrosis and asthma)? <input type="checkbox"/> Do you have a diabetes mellitus or other metabolic diseases? <input type="checkbox"/> Do you have cancer, immunodeficiency, or immunosuppression (due to underlying disease and/or therapy)? <input type="checkbox"/> Do you have renal disease? <input type="checkbox"/> Do you have anemia or hemoglobinopathy?		
Do you have conditions that compromise the management of respiratory secretions and are associated with an increased risk of aspiration?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a child or adolescent with conditions treated for long periods with acetylsalicylic acid?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a pregnant woman?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a household contact/caregiver to an infant less than 6 months old, or a household contact/caregiver to anyone who is immunocompromised?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever developed red eyes and/or respiratory problems such as cough, wheeze, difficulty breathing, hoarseness, sore throat and/or facial swelling within 24 hours after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any of the following?		
- Eggs or egg products	<input type="checkbox"/>	<input type="checkbox"/>
- Thimerosal	<input type="checkbox"/>	<input type="checkbox"/>

You consent to the disclosure of your personal health information (including your record of vaccination) to the family physician that you have named today for the purpose of giving notice that you have received this vaccination. I further confirm that I have read the Influenza Fact Sheet and understand the benefits and possible risks of the vaccine. Any questions I had were answered to my satisfaction.

I agree to wait 15 minutes following injection to be observed for any potential adverse reactions.