MARKHAM-STOUFFVILLE
Urgent Care Centre

[]Seasonal Influenza Vaccine Consent Form-Template[]

[2020-2021]

Last name: _____ First name: _____ Phone number: _____

Street Address: _____ City: _____ Postal Code: _____

Male □ Female □ Date of Birth: Year _____ Month _____ Day _____ Age: _____

For children 6 months of age to less than 9 years of age who have NOT been previously vaccinated with **seasonal** influenza vaccine, is this the first or second dose of seasonal influenza vaccine this year?

First □ Second □ If second, please indicate the date of the first dose: _____/_____/____ (year, month, day)

Are you feeling ill today?	No □	Yes □	If yes, please explain below
Have you ever had an allergic reaction to a vaccine?	No □	Yes □	If yes, please explain below
Are you allergic to: chicken, eggs or egg products	No □	Yes □	If yes, please explain below
thimerosal - in vaccines and contact lens solution	No □	Yes □	If yes, please explain below
gentamicin	No □	Yes □	If yes, please explain below
Do you have a bleeding disorder?	No □	Yes □	If yes, please explain below
Are you taking any medication that could affect blood clotting?	No □	Yes □	If yes, please explain below
Have you ever been diagnosed with Guillain-Barré Syndrome within 6 weeks of receiving a flu vaccine?	No □	Yes □	If yes, please explain below

Please explain any "Yes" answers provided above:

_____

_____

_____

I have read (or it has been read to me) and I understand the "Seasonal Influenza Vaccine Information Sheet". I have had the opportunity to ask questions and to have them answered to my satisfaction. I consent to the seasonal influenza vaccine.

If signing for someone other than yourself, indicate your relationship to that other person: _____

If signing for someone other than myself, I confirm that I am the parent / legal guardian or substitute decision maker.

Signature: _____ Print: _____

Date of signature: _____

Please check if you do not want your information released to another health care provider. ❒

For Clinic Use Only: **□ 1 ½" needle**

VACCINE	DOSE	LOT NUMBER	EXPIRY DATE	SITE / IM	TIME GIVEN	DATE GIVEN	GIVEN BY
	0.5 ml						

Comments: _____

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