**Influenza Immunisation Consent Form 2025/2026(Corporate)**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Directorate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a temperature today? YES / NO

Are you taking any medication? YES / NO

Have you had any vaccinations in the last month? YES / NO

Have you had flu or flu-like symptoms in the last week? YES / NO

Are you pregnant or likely to be? YES / NO

Have you ever had a flu vaccination in the past? YES / NO

If so, did you suffer any side effects from it? YES / NO

Have you ever been advised not to have a flu injection?

Or been refused one by your doctor? YES / NO

If you have answered yes to any of the above questions, please provide details in box below:

|  |
| --- |
|  |

I give my signed consent for the OH staff to administer the Seasonal Influenza Vaccine to me.

Signed: Date:

**Please note details of your Influenza Vaccination will be sent to your GP Surgery**

**FOR OFFICE USE ONLY:**

Batch Number: Expiry date: Right deltoid / Left deltoid

OHA/N: Signature: Date: