**Influenza Immunisation Consent Form 2024/2025(Corporate)**

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

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

Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Are you allergic to egg or egg protein? 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:

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| --- |
|  |

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

Signed: Date:

**FOR OFFICE USE ONLY:**

Batch Number: Expiry date: Right deltoid / Left deltoid

OHA/N: Signature: Date: