SEASONAL INFLUENZA PREVACCINATION CHECKLIST & CONSENT

Pt #

This checklist helps decide about your vaccination requirements.
Please fill in the following information for your doctor / nurse.

Full Name: ___________________________ DOB:____________________ Age today:______________

Screening Checklist (Adapted from the Australian Immunisation Handbook)	**Please tick** √
Do you have a cough , sore / scratchy throat, or feel unwell with any other symptoms	❒ Yes ❒ No
Do you have a disease which lowers immunity, eg leukaemia, cancer or having treatment such as chemotherapy or prednisone	❒ Yes ❒ No
Have you had a reaction following any vaccine	❒ Yes ❒ No
Do you have any severe allergies (to anything) if so *what*?	❒ Yes ❒ No
Have you had another vaccine in the past month	❒ Yes ❒ No
Have you had an injection of immunoglobulin or received any blood products or a whole blood transfusion within the past year	❒ Yes ❒ No
Do you have a past history of Guillain – Barre syndrome	❒ Yes ❒ No
Are you in an occupation or have lifestyle factor(s) for which vaccination may be needed (discuss with doctor/nurse) Please specify:	❒ Yes ❒ No
.Do you have a chronic illness	❒ Yes ❒ No
Do you have a bleeding disorder	❒ Yes ❒ No
Do you identify as an Aboriginal or Torres Strait Islander	❒ Yes ❒ No
Do you have a functioning spleen? (A spleen is an organ involved in the production and removal of blood cells and is part of the body's immune system)	❒ Yes ❒ No ❒ Uncertain
Are you planning a pregnancy or anticipating parenthood	❒ Yes ❒ No
Are you a parent, grandparent or carer of a newborn	❒ Yes ❒ No
Do you have close contact with someone who has a disease that lowers immunity (eg cancer, leukaemia HIV/AIDS) or lives with someone who is having treatment that lowers immunity (eg steroid medications, radiotherapy, chemotherapy)	❒ Yes ❒ No

We recommend you wait in close vicinity for 15 minutes following your immunisation.

- ***If you are here alone please remain in the waiting room so reception can observe you***
- ***If you are with another adult you may return to your vehicle for the 15 minutes – please seek help if you experience any adverse affects following the immunisation.***

Consent to having the seasonal influenza vaccine. **Patient / Carer's signature: X**____________________

Print name: ____________________

I would like to have the vaccine in my ☐ **Left arm** ☐ **Right arm**

SCFH USE

☐ 6/12 - <5yrs ☐ 5 – 64yrs ☐ ≥ 65yrs

Place vaccine Sticker here Batch #

Temp: _______ °

☐ Funded ☐ Private vaccine

Date Given: ____________________

Other vaccine : _________________ Batch:___________________ Doctor: ________ (initials) Imuniser's signature: **X**