☐ Eastern ☐ Central ☐ Western ☐ Lab/Gren

H1N1 Pandemic Influenza Vaccine Consent and Record of Immunization

MCP ______________________
Last Name ______________________ First Name ______________________
DOB ______________________
Address ______________________ Postal Code ______________________
Telephone (h) (w) (c)

Screening Questions	**Check the Correct Box** Yes	No	Unsure
Are you sick or do you have a fever today?	☐	☐	☐
Do you have any medical problems (e.g. previous GBS, heart disease)? If yes, please describe ______________________	☐	☐	☐
Are you pregnant, if yes how many months________?	☐	☐	☐
Do you have a history of allergies? (*medications, vaccine, food e.g. eggs)* If yes, please list______________________	☐	☐	☐
Have you ever had the flu shot before?	☐	☐	☐
Have you ever had a reaction to a flu shot? (*red eyes ,hives, rash, or difficulty breathing)* If yes, please describe______________________	☐	☐	☐

Adverse Reactions

1. Common side effects include: soreness and redness at the injection site that may last up to two (2) days.
2. Less often side effects include: headache, muscular aches/pains, red eyes, cough, and sore throat.
3. Allergic reactions such as breathing problems and hives are very rare and may occur with extreme sensitivity to certain components of the vaccine.

Consent

I understand the information regarding the risks and benefits of the pandemic influenza vaccine provided by the Health Care Provider.

I understand that my or my dependant's vaccination information will be entered in the NL immunization database

I **CONSENT** for me or my dependant to have the pandemic influenza vaccine, two (2) doses for children under age 10 years.

Signature ______________________

Relationship to child/person______________________

Date__________________

Refusal

I understand the information regarding the risks and benefits of the pandemic influenza vaccine provided by the Health Care Provider.

I **REFUSE** for me or my dependant to have the pandemic influenza vaccine

Signature ______________________

Relationship to child/person______________

Date________________

↓ Health Care Provider administering the vaccine to complete↓

Consent: ☐ Contraindicated ☐ Refusal ☐ Consent on file

Target Groups: Tick all that apply

☐ Chronic illness ☐ Resident in remote areas ☐ First responder

☐ Pregnant ☐ Household contact/care provider of infant < 6mos or immunocompromised ☐ Poultry or Swine Worker

☐ Health Care Worker* ☐ Aboriginal resident

*Employed by the Regional Health Authority administering this vaccine ☐ Yes ☐ No

Immunization Record

Date/Time	**Vaccine**	**Antigen Lot #**	**Adjuvant Lot #**	**Box Lot #**	**Dose**	**Route**	**Site**	***Signature***
						IM.		
						IM.		

yyyy/mm/dd