

Staff Influenza Consent

Annual Influenza vaccination is recommended for all health care workers

Name:	Employee Number
Department/Ward	Campus

Are you allergic to egg or chicken feathers?	Yes / No
Are you allergic to Neomycin	Yes / No
Are you suffering an acute illness with fever at present?	Yes / No
Have you previously been vaccinated against the 'flu?	Yes / No
Are you presently taking Warfarin, Theophylline or Dilantin?	Yes / No
Are you pregnant or breastfeeding?	Yes / No
Have you ever felt faint or fainted after an injection or giving blood?	Yes / No

The influenza vaccine is generally well tolerated. Most unwanted side effects are mild and clear up in 1-2 days. These effects generally occur around the injection site.

More common side effects include ...

- Redness, swelling, a hard lump, soreness, bruising or itching around the injection site
- Muscle aches and pains, tiredness
- Much less commonly: Fever, chills headache and a general feeling of being unwell that may last 1-2 days.

More serious, but rare side effect include...

- Immediate reactions such as hives, itching (especially of the hands and feet) and/or reddening of the skin, other more severe skin reactions.
- Shortness of breath, breathing or swallowing difficulties
- A significant increase in Guillain-Barre Syndrome (GBS), a rare disease affecting nerves, was associated with an influenza vaccine used in 1976. Subsequent to this, the excess risk of GBS associated with influenza vaccine has been estimated as 1 per million doses. If you have suffered from GBS in the past, please inform us before vaccination.

Consent for vaccination

I have read and have understood this information and consent to receiving an influenza vaccine. I also understand that I must stay within the immediate vicinity of the health professional for 15 minutes after my vaccination. I consent to the administration of the influenza vaccine.

Signature: _____ Date: _____

Vaccine:	Batch No.
Administered by:	Date:

Please complete below if you decline to participate in vaccination for seasonal influenza

I decline to participate in vaccination for seasonal influenza.

Reason for declining vaccination	
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I am aware of the potential risks my non participation in seasonal influenza vaccination may pose and that non-participation will require my employer to manage me as unprotected from seasonal influenza

Name (Please Print):	Signature												
Employee Number:	Department/Ward												
Campus													
Occupational Group Please circle	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Clinical staff</td> <td style="width: 50%;">2. Non –clinical staff</td> </tr> <tr> <td>a)Medical staff</td> <td></td> </tr> <tr> <td>b)Nursing staff</td> <td></td> </tr> <tr> <td>c)Allied Health staff</td> <td></td> </tr> <tr> <td>d) Laboratory staff</td> <td></td> </tr> <tr> <td>e) other staff</td> <td></td> </tr> </table>	Clinical staff	2. Non –clinical staff	a)Medical staff		b)Nursing staff		c)Allied Health staff		d) Laboratory staff		e) other staff	
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Do you work in the Emergency Department? (Circle appropriate Box) Yes No