

# Influenza Vaccination Consent Form

Patient ID no

## Patient Details

For completion by Patient or person on behalf of patient:

First Name ..... Surname.....

Date of Birth .....

<b>Allergies</b> <i>Please circle where appropriate</i> Are you allergic to chicken or eggs? Yes / No Do you have any other allergies? Yes / No If Yes Please indicate to what .....
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**Please tick if you are aged 65 or over (or if you will be aged 65 before 31st March of next year)**

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## **For Completion by clinician administering the vaccine:**

**If patient is aged under 65 years please indicate below a Clinical Risk/ reason for vaccine**

- Asthma  COPD  Diabetes  Heart Disease  Renal disease  Liver Disease   
Stroke TIA  Immunosuppressed  Disease of central nervous system  Poultry Worker   
Carer

**Vaccine has been administered but no clinical risk/ reason identified**

I have explained the procedure to the patient. I have also discussed what the procedure is likely to involve, the benefits and the risks of any alternative treatments (including no treatment) and any other particular concerns of the patient.

**Given by:** ..... **Batch No /Expiry Date** ..... **Left / Right Arm**

**Patient Signature:** ..... **Date:** .....