Revised Nov 2.2023

2023-2024 Influenza Vaccine Consent Form

Client Information

Last Name: _____ First Name: _____

Date of Birth (YYYY-MM-DD): _____ Age: _____

Postal Code: _____ Phone Number: _____

Screening Questions

Check "Yes" or "No" to the following questions.	YES	NO
Are you feeling well today?		
Have you ever had a serious allergic reaction (anaphylaxis) to the flu vaccine?		
Do you have any allergies?		
Have you ever had Guillain-Barré Syndrome (GBS) within 6 weeks of receiving a flu vaccine?		
Have you ever had Oculo-Respiratory Syndrome (ORS) within 24 hrs of receiving a flu vaccine?		
(If under 9 years of age): Have you ever had the flu vaccine?		

Personal information is collected under the authority of the Personal Health Information Protection Act and/or the (Municipal) Freedom of Information and Protection of Privacy Act. For more information about the collection or use of this information, contact the FOI Coordinator, 194 Terrace Hill Street, Brantford, ON N3R 1G7, 519-753-4937, Ext. 222.

Consent & Documentation (Vaccinator Use Only)

Verbal informed consent obtained from (Check Box):

☐Client ☐Parent/Guardian Name: _____

Date (YY-MM-DD) & Time Administered	Vaccine Product	Site (Check Box)	Lot Number Expiry (YY-MM-DD)	Vaccinator's Name & Signature. Please both print name and sign signature
Date:	☐ Fluzone® QIV **Regular** 0.5mL (≥ 6 m) **MDV**	☐ Deltoid Left ☐ Deltoid Right ☐ Thigh Left ☐ Thigh Right	☐U8097BA, 2024-06-30 ☐U8086AA, 2024-06-30 ☐ Other:_____	Name: _____
Time:	☐ Fluzone® **High Dose** QIV 0.7mL (≥ 65 yrs.) **PFS**		☐ U8095AA,2024-06-30 ☐ U8095CA,2024-06-30 ☐ U8165BA,2024-06-30 ☐ Other:_____	Signature: _____

BRANT COUNTY HEALTH UNIT