

# QUINNS MINDARIE SUPER CLINIC

## INFLUENZA VACCINATION CONSENT FORM

Eligibility for influenza vaccines funded by the National Immunisation Program (NIP)

**Please tick one of the following:**

- I am entitled to have a free government funded flu vaccination because I am 65 years of age or over
- I am not eligible for the government funded free flu vaccination and will be having a private influenza vaccine today
- I am entitled to have a free government funded flu vaccination because I have one of the medical conditions assessed by the National Immunisation Program to be at higher risk of complications if I get the flu.

***These conditions are listed in the table below. Please tick which medical condition relates to you. If you are not sure please speak with your doctor before having the vaccination.***

Please tick the box below if you have any of the medical conditions outlined in the table below.

Category	Medical Condition	Yes	No
Cardiac Condition	Congenital heart disease, congestive heart failure, coronary artery disease		
Chronic Respiratory Conditions	Severe asthma, cystic fibrosis, bronchiectasis, lung disease, chronic obstructive pulmonary disease, chronic emphysema		
Chronic Neurological Conditions	Hereditary and degenerative central nervous system disease, seizure disorders, spinal cord injuries, neuromuscular disorders		
Immunocompromising Conditions	Immunocompromised due to disease or treatment, abnormal spleen function, HIV infection		
Diabetes and other Metabolic Disorders	Type 1 or 2 diabetes, chronic metabolic disorders		
Renal Disease	Chronic renal failure		
Haematological Disorders	Haemoglobinopathies such as sickle cell disease		
Long Term Aspirin Therapy in Children Aged 6 Months to 10 Years	Increased risk following influenza infection		

**None of the above medical conditions**

The following information is needed to assess whether a person/child can be vaccinated with the flu vaccine. Please tick and let the immunisation provider if any of the following apply:

The person to be vaccinated:

- have you had a COVID-19 vaccine YES/NO (please circle)
- is currently unwell
- has had a severe reaction to any vaccine
- is allergic to Latex

**(please see over)**

- has any severe allergies to anything, especially to antibiotics
- has a disease which lowers immunity (e.g. cancer, leukaemia, HIV)
- is having treatment which lowers immunity (e.g. radiotherapy, chemotherapy, steroid medication)
- lives with someone who has a disease which lowers immunity or having treatment which lowers immunity
- has a chronic disease (e.g. diabetes, heart disease, asthma, epilepsy)
- has had a vaccine containing live viruses with the last month (e.g. MMR, yellow fever), or an injection of immunoglobulin or a blood transfusion within the last 3 months
- is pregnant
- has a disease of the brain or spinal cord
- has had a convulsion or a fit.
- Other Illness: \_\_\_\_\_
- Do you or your child identify as Aboriginal or Torres Strait Islander?  Yes  No
- Have you had an influenza vaccination previously?  Yes  No
- If you are aged 70 years and older have you had a Pneumococcal vaccination?  Yes  No
- If you aged between 70 years and 79 years have you had a Zostavax (shingles) vaccination?  Yes  No
- Do you consent to Smartvax sending an SMS message in 3 days to monitor for any reaction to the Vaccination?  Yes  No

Note: If you have questions about this information or any matter related to immunisation please ask one of the clinic staff **before** the vaccine is given.

I have read and understood the advice sheet about possible reactions.

I have read and understood the information above and give consent to the immunisation. I also consent to the information being sent to the Australian Immunisation Register.

Patient First Name: .....Surname: ..... Date of Birth: .....

Signed: ..... Parent or Guardian Name: ..... Date: .....

Office Use Only

VACCINE	BATCH #	SITE		GIVEN BY	REMINDER	ENTERED BY
		RA	LA			
		RA	LA			