Influenza Vaccination Consent Form

SURNAME _____ **FIRST NAME** _____

ADDRESS _____

DEPARTMENT / DIVISION _____

CONTACT NUMBER _____ **DATE OF BIRTH** _____

MEDICAL CENTRE/GP _____ **NHI** _____

NHI (National health Index) number **if known**

ETHNICITY (PLEASE TICK ONE OR MORE):

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian

Other - please state: _____

CONSENT STATEMENTS

☐ I have read the fact sheet called 'What you need to know about the flu vaccination'.

☐ The benefits and risks of the flu vaccine have been explained to me and I have been told how long I will need to wait after the vaccination.

☐ I had enough time to ask questions and my questions were answered to my satisfaction.

☐ I have received or photographed the fact sheet so I can refer to it after I leave the appointment. 'What you need to know about the flu vaccination.'

☐ I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.

☐ The vaccinator has discussed with me other vaccines for which I am eligible.

☐ I understand this vaccination information will be recorded on **either** of the Ministry of Health Registers the AIR (Aotearoa Immunisation Register) or CIR (Covid Immunisation Register) and will be shared with my regular healthcare provider.

☐ I consent to the flu vaccination being given.

SIGNATURE _____ **DATE** _____

VACCINATION RECORD (FOR VACCINATOR USE)

Details confirmed ☐ Affirmative answer to any screening questions? ☐ Yes ☐ No

Record information and advice given: _____

Information consent obtained: ☐ Yes ☐ No

Vaccine Details					
Name of vaccine	**Batch**	**Dose**	**Site**	**Date**	**Time**
AFLURIA QUAD	380302 expiry 02/2025	0.5mL			

Vaccinator information
Place of vaccination::
Name:
Signature:

Observation period information	
Details of any AEFI or observations recorded	☐
CARM Report completed via the CARM website	☐
Signature:	
Departure time:	