MPS Inactivated Influenza Vaccination Consent Form 2022-23
For MPS-INFLUENZA-2223 PGD

For completion by applicant/parent/guardian (Gillick Competencies may apply)

MEDICAL PRESCRIPTION services

APPLICANT DETAILS:

Full name: ……..

Address: ……

…… Post code ……

Contact number: ……..

G.P. DETAILS:

DR. ……

Practice address: ……..

……

Applicant's D.O.B. ……..

Seasonal influenza vaccine applicants must be **at least TWO years** of age:

Known allergies: ……

Applicant Consent (please circle the appropriate answer):

1. Do you have a severe febrile illness or acute infection today?	YES	NO
2. Have you had a complete dose of flu vaccine this season?	YES	NO
3. Have you ever had a severe allergic reaction to any of the following? Eggs and/or chicken proteins An antibiotic A previous influenza vaccine Latex (natural rubber)	YES	NO
4. Do you have any form of bleeding disorder (i.e. Haemophilia) or take any medicines that affect the way your blood clots?	YES	NO
5. Is your immune system effected by a medical condition (i.e. HIV/AIDS) or medicines you take (i.e. steroids / chemotherapy)?	YES	NO
FEMALES ONLY: Are you pregnant or breastfeeding?	YES	NO

The applicant (or their representative) has provided the details above and has confirmed that they are correct and complete and that there are no contraindications that would prevent the applicant from receiving an influenza vaccine today.
They have been made aware of the potential side-effects and how to manage them. They understand that there is a small risk of a reaction to the vaccine and accept that the pharmacist is not responsible if they do have a reaction.
They understand that having an influenza vaccine does not guarantee that they will not catch influenza this flu season.

Consent to receive the inactivated seasonal influenza vaccine YES ☐ NO ☐

Date:_____ Signature of PHARMACIST:_____

To be completed by the Pharmacist:

Name/Brand of influenza vaccine given:

DELTOID MUSCLE: IM / SC **LEFT ARM** **RIGHT ARM** Batch number: Expiry date:

Adverse effects following vaccination? ……

I confirm this applicant is eligible for the seasonal influenza vaccine. I have explained about the vaccination, its possible side-effects and how to manage them. I have also provided advice and written information about the vaccine. I confirm I have referred to **MPS-INFLUENZA-2223** and the consultation was carried out fully in accordance with the PGD.

Signature: …… **Name and GPhC/PSNI number:** ……

Pharmacy name and Post Code: …… **Tel:**

Location at which the vaccine was administered (if not the pharmacy) e.g. business: ……