QUESTIONNAIRE AND CONSENT FORM INFLUENZA VACCINE

Name: ______________________________

Date of birth :______________________ Company : ______________________

*** The personal information contained in this questionnaire will remain strictly confidential and will not, under any circumstances, be transmitted to your employer. ***

QUESTIONS	YES	NO
1. Are you feeling well today?		
2. Have you read the information regarding the risks and benefits of being immunized against influenza?		
3. Have you been ill in the past 10 days? Specify : ______________________		
4. Have you had fever in the last 48 hours? Specify Tº : ______________		
5. Do you have a coagulation (bleeding) disorder? (or take medication such as Coumadin)		
6. Do you have any allergies? (ex : thimerosal, latex, neomycin) Specify : ______________________		
7. Do you have an anaphylactic reaction to egg or egg products? (the answer is NO if you are able to eat cakes and/or muffins)		
8. Are you currently taking any medication? Specify : ______________________		
9. Have you ever had a reaction to a previous vaccine (including fainting after receiving the vaccine) other than feeling pain at the injection site? Which vaccine :______________ Reaction : ______________		
10. Do you have an immunodeficiency disorder? (i.e.: cancer treatment, HIV infection, high doses of steroids, graft)		
11. Are you pregnant or do you think you may be pregnant*?		
12. Do you have or have you had a neurological disorder (Guillain Barré)?		
13. **If you are a pilot or a flight attendant :** When are you scheduled to fly next : ______________ Please note that you must be symptom free at least 48 hours and wait at least 48 hours and following flu vaccine before operating a flight.		

*This is not a contraindication to receiving the vaccine against influenza.

I, undersigned, authorize the personnel of MEDISYS and its representatives to proceed with the immunization against influenza.

I have been advised of the potential risks of this immunization**. I confirm that I understand that, as a precautionary measure, I must remain at the vaccination site for at least 15 minutes and must remain in the building for at least 30 minutes after receiving the vaccine.**

All of our information-handling practices comply with applicable federal and provincial laws including the Personal Information Protection and electronic documents Act.

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Candidate's signature

*****PLEASE BRING THE COMPLETED FORM TO THE VACCINATION CLINIC*****

☐ Authorization to give immunization ☐ Questionnaire verified

______________________________ Date :______________ Time : ______________

Nurse's signature

______________________________ Date :______________ Time : ______________

Nursing assistant's signature

Vaccine		Strains	Lot number	Injection site	
Fluviral 3	☐	A/Michigan/45/2015 (H1N1)pdm09	Please place sticker here	Right deltoide	☐
Agriflu 3	☐	A/Singapore/INFIMH-16-0019/2016 (H3N2)		Left deltoide	☐
Vaxgrip 3	☐	B/Phuket/3073/2013 (Yamagata)			
Fluzone 4	☐	B/Colorado/06/2017 (Victoria) - Quad vaccine			
Flulaval 4	☐				