

Consent Form

Last name:	_____	Municipality code:	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table>						
First name:	_____	Date of birth:	<table border="1"><tr><td>__</td><td>__</td><td>__</td></tr><tr><td>yy</td><td>mm</td><td>dd</td></tr></table>	__	__	__	yy	mm	dd
__	__	__							
yy	mm	dd							
Address:	_____	Male:	<input type="checkbox"/>						
Postal code:	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>							Female:	<input type="checkbox"/>

Check off any of the following that apply

Risk Group

Are you a:

First responder (police, firefighter)	Yes	No
Poultry worker	Yes	No
Health-care worker	Yes	No
65 years old or older	Yes	No
Pregnant woman	Yes	No
Resident/staff/volunteer in a nursing home or school residence	Yes	No
Household contact/caregiver to an infant less than six months old	Yes	No
Household contact/caregiver to anyone who is immunocompromised	Yes	No

Health Information

Do you have any of the following health conditions:

Cardiac disorder	Yes	No
Pulmonary disorder	Yes	No
Diabetes	Yes	No
Cancer, immunodeficiency, or immunosuppressed	Yes	No
Anemia	Yes	No
Renal disease	Yes	No
Neurological problems	Yes	No
Guillain Barré syndrome	Yes	No
Other	Yes	No

Allergies

Are you allergic to any of the following:

Eggs and egg products	Yes	No
Thimerosal	Yes	No
Neomycin	Yes	No
Formaldehyde	Yes	No
Other	Yes	No

Acknowledgement and Waiver

I read the flu shot information. I had the chance to ask questions that were answered to my satisfaction. I consent to receiving the influenza vaccine. I understand that I must wait under observation at the clinic for 15 minutes after I get the shot.

Client Signature:	Date:
Parent/guardian signature (if applicable):	

For Nurse's Use Only:

Seasonal Influenza	Fluviral	
	Vaxigrip	
Dosage	0.25 ml IM	
	0.5 ml IM	
Site		
Deltoid	Right	
	Left	

Lot#	
Expiry date	
Time given	
Anterolateral Thigh	Right
	Left

H1N1 Influenza	Adjuvant	
	Non-Adjuvant	
Dosage	0.25 ml IM	
	0.5 ml IM	
Site		
Deltoid	Right	
	Left	

Dosage	
Lot # Adjuvant	
Lot # Vaccine	
Expiry Date	
Time	
Anterolateral Thigh	Right
	Left

Administered by: _____ Date: ____/____/____
 yyyy mm dd

As per Medical Directive # CHDP IV 110
 The information on this form is collected under the authority of the *Health Protection and Promotion Act* in accordance with the *Municipal Freedom of Information and Protection of Privacy Act* and the *Personal Health Information Protection Act*. This information will be used for the delivery of public health programs and services; the administration of the agency; and the maintenance of health care databases, registries and related research, in compliance with legal and regulatory requirements. Any questions about the collection of this information should be addressed to the Privacy Officer.



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