

Title: Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Other <input type="checkbox"/>		D.o.B.: __ / __ / __		Age: _____	
Name:		Home Address:			
Surname:					
Email:		Name & Address of GP (optional)			
Telephone:		Would you like your GP to be informed of this consultation? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Please answer the following questions (must be completed by parent or guardian if under 16)					
Do you feel unwell, have a temperature or an infection?		Yes <input type="checkbox"/> No <input type="checkbox"/>		Women only: Are you currently breast-feeding?	
Have you ever had an allergic or anaphylactic reaction to an influenza vaccine or any other vaccine before? <i>If yes, please describe the reaction</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have any allergies (e.g. egg, latex, antibiotics)? <i>If yes, please describe the allergy/reaction</i>	
Women only: Are you pregnant, or is there any possibility that you could be pregnant?		Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine?	
Are you immunosuppressed due to disease or treatment (e.g., HIV)? <i>If yes, please provide details</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have any recent or past medical history of note? <i>If yes, please provide details</i>	
Do you have a bleeding disorder, including taking any medication that thins your blood (anticoagulants)?		Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you aware that some people in high risk groups may be entitled to have the Flu vaccine free on the NHS? <i>Your pharmacist will discuss this with you if you are eligible</i>	
Are you aware that the vaccine may not fully protect everyone who receives it?		Yes <input type="checkbox"/> No <input type="checkbox"/>		Have you already had a flu vaccine for this flu season?	
Do you have a hereditary and degenerative disease of the nervous system or muscles; or a severe neurological disability or learning disability?		Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have severe asthma, difficulty breathing, or are you receiving salicylate therapy?	
Please list all your current prescription medication including any medication you buy over the counter					

CONSENT

I have received information on the risks and benefits of the vaccine and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the vaccine being given.

Signature of patient, parent or guardian _____ Date _____

HEALTHCARE PROFESSIONAL USE ONLY					
Vaccine brand, batch number and expiry date	<i>Affix vaccine label here or write details</i>	Site of injection	Route of administration	Date	Cost
		L deltoid <input type="checkbox"/>	Intramuscular <input type="checkbox"/>		
		R deltoid <input type="checkbox"/>	Subcutaneous <input type="checkbox"/>		
		Anterolateral thigh <input type="checkbox"/>	Nasal (Fluenz Tetra) <input type="checkbox"/>		
I confirm that the patient is not contraindicated based on the information provided by the PGD					<input type="checkbox"/>
I have explained the potential warnings and side effects of the vaccine to the patient, and requested they report them if they occur					<input type="checkbox"/>
I have provided the patient with an information leaflet (PIL) for the vaccine I am administering, and advised them to read it					<input type="checkbox"/>
Healthcare Professional Name			Signature		