CBI HEALTH GROUP

SEASONAL INFLUENZA VACCINE
Questionnaire & Consent

Part A: Questions

Read each question carefully

Circle your answers. **DO NOT GUESS**. Answer **YES** if you are not certain.

1. Do you have a respiratory infection or other active infection, illness or fever? Y N
2. Do you have severe asthma on high dose inhaled glucocorticoids or active wheezing ? Y N
   (**do not give vaccine)**
3. Do you have a history of Oculo-Respiratory syndrome (ORS)? Y N
4. Are you taking any anti-coagulants (blood thinners)? Y N
   (**watch for bleeding at injection site, add pressure)**
5. Do you have a history of Guillain-Barre Syndrome (GBS)? Y N
6. Are you allergic to eggs, or egg products Y N
   If you answered YES, please complete supplemental questionnaire for egg allergy (FLU – 01b)
7. Are you allergic to Thimerosal, Formaldehyde, Neomycin sulfate, Streptomycin, Gentamycin, Bromide, polysorbate 80 or Kanamycin Y N
8. Have you had an anaphylactic reaction to a previous dose of Influenza vaccine Y N
   (do not give vaccine)

NOTE: If you answered YES to any of the above questions, you MAY not be eligible to receive the flu vaccine at this clinic. Please speak with the nurse for further information regarding your options. If there is any issue with your medical history, a doctor's note is advised.

Part B: Voluntary Consent

I have read the Influenza information sheet and understand the benefits, side effects and risks associated with receiving a Flu shot, and the consequences of not having a Flu shot. I have had the opportunity to ask questions and received answers to my satisfaction. I have answered the above questions accurately and wish to receive the seasonal influenza vaccination on a voluntary and informed basis. I hereby absolve CBI Health Group, of any and all responsibility and I authorize CBI Health Group nurses to administer to me, the seasonal influenza vaccine, by intramuscular injection. My confidentiality and privacy will be respected at all times. No personal identifying information will be shared.

Client to complete

_____

Last Name First Name DOB: Day/Month/Year

_____

Address City/Town Province Phone No.

_____ _____

Date Signature

Nurse to complete

_____

Print Name Signature Date Time