

2024 Flu vaccination consent form



Don't want to take this fact sheet with you? Take a photo instead! It's important to keep this information handy.

Person

Surname _____ First name _____

Phone _____ Date of birth / / Age years
DD MM YYYY

Address _____

Medical Centre/GP _____ NHI _____
National Health Index number if known

Ethnicity (please tick one or more)

NZ European Māori Samoan Cook Island Māori Tongan Niuean Chinese

Indian Other – please state _____

Consent statements

- I have read the fact sheet called 'What you need to know about the flu vaccination'.
- The benefits and risks of the flu vaccine have been explained to me and I had enough time to ask questions and my questions were answered to my satisfaction.
- I have been told how long I will need to wait after the vaccination.
- I have received or photographed the fact sheet so I can refer to it after I leave the appointment. 'What you need to know about the flu vaccination.'
- I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.
- The vaccinator has discussed with me other vaccines that I am eligible for.
- I understand this vaccination information will be recorded and shared with my/the vaccinated person's regular healthcare provider.
- I consent to the flu vaccination being given.

Signature _____ Date / /
DD MM YYYY

As parent / legal guardian / enduring power of attorney

I _____ am the parent, legal guardian or enduring power of attorney, and agree to the flu vaccination of the person named above.

Relationship to person being vaccinated _____ Phone _____

Signature _____ Date / /
DD MM YYYY

Vaccination record (for vaccinator use)

Consumer details confirmed Affirmative answer to any screening questions? Yes No

If yes, record the detail and advice given _____

Verbal and written post vaccination information given Other vaccines discussed

Informed consent obtained? Yes No

Influvac Tetra (Funded) 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> 6 months – 9 years
Flucelvax Quad (Unfunded) 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> 6 months – 9 years
Fluad Quad (Unfunded) 65 years	Dose 1 <input type="checkbox"/> 6 months and over	
FluQuadri (Unfunded) 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> 6 months – 9 years
Afluria Quad (Unfunded) 3 years and over	Dose 1 <input type="checkbox"/> 3 years and over	Dose 2* <input type="checkbox"/> 3 – 9 years

*Two doses separated by at least four weeks if a flu vaccine is being administered for the first time.

Flu vaccination details

Name of vaccine	Batch	Expiry	Dose	Needle size	Site	Date	Time
(write vaccine name or place vaccine sticker here)					Deltoid <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Funded <input type="checkbox"/> Non-funded							

Vaccinator information

Place of vaccination _____

Name _____

Signature _____

Observation period

Details of any AEFI or observations recorded

CARM report completed

Signature _____

Departure time _____

Clinical supervisor**

Name _____

Signature _____

** if relevant