2024 Flu vaccination consent form

Person

Surname ______________________ First name ______________________

Phone ______________________ Date of birth ___/___/_____ (DD MM YYYY) Age _____ years

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 ☐ 6 months and over	Dose 2* ☐ 6 months – 9 years
Flucelvax Quad (Unfunded) 6 months and over	Dose 1 ☐ 6 months and over	Dose 2* ☐ 6 months – 9 years
Fluad Quad (Unfunded) 65 years and over	Dose 1 ☐ 65 years and over	
FluQuadri (Unfunded) 6 months and over	Dose 1 ☐ 6 months and over	Dose 2* ☐ 6 months – 9 years
Afluria Quad (Unfunded) 3 years and over	Dose 1 ☐ 3 years and over	Dose 2* ☐ 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) ☐ Funded ☐ Non-funded					Deltoid ☐ L ☐ R		

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

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