2025 Flu vaccination consent form

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', and kept a copy or photographed so I can refer to it after I leave the appointment.
- ☐ The benefits and risks of the flu vaccine have been explained to me. I have had enough time to ask questions and my questions were answered to my satisfaction. I have been advised of the different types of flu vaccine available to me and my options.
- ☐ I have been told how long I will need to wait after the vaccination.
- ☐ I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms after the immunisation which may be vaccine related.
- ☐ The vaccinator has discussed with me other vaccines that I am eligible for.
- ☐ I understand this vaccination will be recorded by Health New Zealand on the Aotearoa Immunisation Register (AIR) and can be accessed by authorised health care staff e.g my GP.
- ☐ I have been provided with the AIR privacy information.
- ☐ **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 ☐

Previous vaccination records checked prior to administration and other eligible vaccines offered eg Tdap / MMR / Shingles ☐

Discussed with consumer influenza vaccines available and pros and cons of these as appropriate ☐

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		

Other vaccines given (vaccinator must ensure informed consent has been obtained for these)

Vaccine details	Batch	Expiry	Dose	Needle size	Site	Date	Time
Write vaccine name or place vaccine sticker here					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 (if relevant)

Name _____ Signature _____

HP7990 | 2025 Flu vaccine consent form | 11.02.25