

## Consent To Receive Seasonal Inactivated Influenza Vaccine

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PRINT Name	
Home Address	
Post Code	
Contact Telephone Number	
Date of Birth	
Directorate	
Department	
Job Title	

**Please answer these questions to the best of your knowledge:**

No.	Question	YES	NO
1	Do you currently feel unwell; have a temperature or an infection?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you had a severe reaction to any medicines, including Flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3	Do you have any allergies, including eggs or chicken? If yes, an alternative vaccine should be available from your GP.	<input type="checkbox"/>	<input type="checkbox"/>
4	Are you allergic to any of the vaccine components identified on the patient information sheet ?	<input type="checkbox"/>	<input type="checkbox"/>
5	Are you pregnant or think you may be? (where relevant) If yes- please inform your GP that you have received the Flu vaccine.	<input type="checkbox"/>	<input type="checkbox"/>
6	Are you currently taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>

## Consent To Receive Seasonal Inactivated Influenza Vaccine

**I consent to receiving the vaccination:**

- I have read the patient information leaflet for the seasonal influenza vaccine. This is available at: <https://www.medicines.org.uk/emc/files/pil.9382.pdf>
- I understand the risks and benefits of having the vaccine
- I have been informed of possible side-effects and reasons why I should not receive the vaccine
- I have had the opportunity to ask questions and have received satisfactory answers
- I agree that NHSBT can store my personal records in line with GDPR

Signature.....

Date.....

**This section to be completed by the Registered Nurse:**

Record details relating to 'YES' ticks. Document reasons for not giving vaccine/person declining vaccine administration, where relevant:

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Vaccine name.....

Batch number (or affix supplied vaccine label) .....

Expiry date.....

Dose administered..... Time given.....

Vaccination site (please tick):      Left deltoid       Right deltoid

**Vaccinator**

PRINT Name.....

Job role & Team.....

Signature.....

Date.....