HEALTHSERV Professionals Inc.

Questionnaire and Consent to receive the Influvac Vaccine

Bring this form with you to the immunization clinic. Please wear short sleeves.

ALL QUESTIONS MUST BE ANSWERED BEFORE IMMUNIZATION IS GIVEN

Your personal information is collected under section 26(c) of the Freedom of Information and Protection of Privacy Act for the purpose of safely administering the Influvac Vaccine. Questions about the collection or use of this information can be directed to the Program Manager, Workplace Health and Safety, BC Public Service Agency, 2-810 Blanshard St, Victoria, BC V8W 9V1, by email at cold.flu@gov.bc.ca, or by calling 250 952-0446.

Name: _____
FIRST **LAST**

Worksite Address:_____ **City/Town:**_____

Please check your Ministry or Organization:

- □ Advanced Education, Skills and Training
- □ Agriculture
- □ Attorney General
- □ BC Pension Corporation
- □ BC Public Service Agency
- □ Children and Family Development
- □ Citizens' Services
- □ Destination BC Corporation
- □ Education
- □ Elections BC
- □ Emergency Management BC
- □ Energy, Mines and Petroleum Resources
- □ Environment and Climate Change Strategy
- □ Environmental Assessment Office
- □ Finance
- □ Forest Practices Board
- □ Forests, Lands, Natural Resource Operations, and Rural Development
- □ Government Communications and Public Engagement
- □ Health
- □ Indigenous Relations and Reconciliation
- □ Intergovernmental Relations Secretariat
- □ Islands Trust
- □ Jobs, Trade, and Technology
- □ Labour
- □ Legislative Assembly
- □ Liquor Distribution Branch
- □ Mental Health and Addictions
- □ Municipal Affairs and Housing
- □ Office of the Auditor General
- □ Office of the Chief Information Officer
- □ Office of the Information and Privacy Commissioner
- □ Office of the Merit Commissioner
- □ Office of the Ombudsperson
- □ Office of the Police Complaint Commissioner
- □ Office of the Premier
- □ Public Safety and Solicitor General
- □ Representative for Children and Youth
- □ Royal BC Museum
- □ Social Development and Poverty Reduction
- □ Tourism, Arts and Culture
- □ Transportation and Infrastructure

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Please check the appropriate answer (all following questions must be answered yes or no)

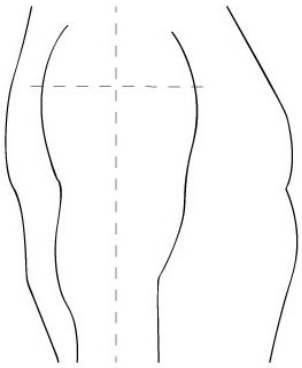
1. Are you allergic to eggs or egg products or chicken protein? ☐ Yes ☐ No
   (Hives, swelling of the mouth or throat, difficulty breathing, changes in blood pressure)
2. Are you allergic to: Formaldehyde, gentamicin (Garamycin, Neomycin, Kanamycin), cetyltrimethylammonium bromide (CTAB), polysorbate 80? ☐ Yes ☐ No
3. Have you ever had a reaction to a flu immunization or other injection? ☐ Yes ☐ No
4. Do you presently have an active infection, illness or fever? ☐ Yes ☐ No
5. Do you have a bleeding or neurological disorder? ☐ Yes ☐ No
6. Are you presently taking medication such as Theophylline, anticoagulants (eg. Warfarin) or corticosteroids (eg. Prednisone)? ☐ Yes ☐ No
7. Are you presently on immunosuppressive therapy? ☐ Yes ☐ No
8. Are you pregnant? Please indicate: ☐ Yes ☐ No

1st Trimester (with physician note)_____ 2nd Trimester___ 3rd Trimester___

I, _____ acknowledge that I understand the risks and benefits associated with this immunization. I give my consent to the administration of the influenza vaccine.

Date: _____ Signature: _____
DAY / MONTH / YEAR

Some people may experience minor side effects such as soreness, redness and swelling at the injection site up to 2 days. Less frequent side effects include fever, malaise, or muscle aches within 6-12 hours, lasting for 1-2 days. If these symptoms persist or worsen, ***contact your physician or a medical clinic****. Please also* ***report this to HEALTHSERV*** *at 1-866-663-5848.*



To be completed by the Occupational Health Nurse:

Manufacturer: Mylan **Dose:** 0.5 ml **Route:** IM Deltoid

(check one) ☐ R or ☐ L **Lot#:** _____ **Expiry:** _____

Immunization Date: _____ **Nurse Signature:** _____
DAY/MONTH/YEAR