



HEALTHSERV Professionals Inc.

Questionnaire and Consent to receive the Influvac Vaccine

Bring this form with you to the immunization clinic.

Please wear short sleeves and a mask to your appointment

ALL QUESTIONS MUST BE ANSWERED BEFORE IMMUNIZATION IS GIVEN

Name: _____
FIRST LAST

Worksite Address: _____ City/Town: _____

Please check your Ministry or Organization:

<input type="checkbox"/> Advanced Education and Skills Training	<input type="checkbox"/> Infrastructure BC
<input type="checkbox"/> Agriculture, Food and Fisheries	<input type="checkbox"/> Intergovernmental Relations Secretariat
<input type="checkbox"/> Attorney General	<input type="checkbox"/> Islands Trust
<input type="checkbox"/> BC Infrastructure Benefits	<input type="checkbox"/> Jobs, Economic Recovery and Innovation
<input type="checkbox"/> BC Pension Corporation	<input type="checkbox"/> Labour
<input type="checkbox"/> BC Public Service Agency	<input type="checkbox"/> Mental Health and Addictions
<input type="checkbox"/> Children and Family Development	<input type="checkbox"/> Municipal Affairs
<input type="checkbox"/> Citizens' Services	<input type="checkbox"/> Office of the Auditor General
<input type="checkbox"/> Consumer Protection BC	<input type="checkbox"/> Office of the Human Rights Commissioner
<input type="checkbox"/> Destination BC	<input type="checkbox"/> Office of the Information and Privacy Commissioner
<input type="checkbox"/> Education	<input type="checkbox"/> Office of the Merit Commissioner
<input type="checkbox"/> Elections BC	<input type="checkbox"/> Office of the Ombudsperson
<input type="checkbox"/> Emergency Management BC	<input type="checkbox"/> Office of the Police Complaint Commissioner
<input type="checkbox"/> Energy, Mines and Low Carbon Innovation	<input type="checkbox"/> Office of the Premier
<input type="checkbox"/> Environment and Climate Change Strategy	<input type="checkbox"/> Public Guardian Trustee
<input type="checkbox"/> Environmental Assessment Office	<input type="checkbox"/> Public Safety and Solicitor General
<input type="checkbox"/> Finance	<input type="checkbox"/> Representative for Children and Youth
<input type="checkbox"/> Forest Practices Board	<input type="checkbox"/> Royal BC Museum
<input type="checkbox"/> Forests, Lands, Natural Resource Operations and Rural Development	<input type="checkbox"/> Social Development and Poverty Reduction
<input type="checkbox"/> Government Communications and Public Engagement	<input type="checkbox"/> Tourism, Arts, Culture and Sport
<input type="checkbox"/> Health	<input type="checkbox"/> Transportation and Infrastructure
<input type="checkbox"/> InBC Investment Corporation	<input type="checkbox"/> Transportation Investment Corporation
<input type="checkbox"/> Indigenous Relations and Reconciliation	<input type="checkbox"/> Other: _____

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

Name: _____
FIRST LAST

Company: _____

Worksite Address: _____ City/Town: _____

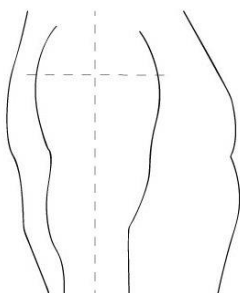
Please check the appropriate answer (**all following questions must be answered yes or no**):

- Do you have an anaphylactic reaction to eggs, egg products, chicken protein?
(Hives, swelling of the mouth or throat, difficulty breathing, changes in blood pressure)
Check "No" if you eat foods containing egg (eg. baked goods). Yes No
- Are you allergic to: Formaldehyde, gentamicin (Garamycin, Neomycin, Kanamycin), cetyltrimethylammonium bromide (CTAB), polysorbate 80? Yes No
- Other than feeling pain at the injection site, have you ever reacted to a flu immunization or other injection (eg. fainting after receiving the vaccine)? Yes No
- Do you presently have an active infection, illness or fever? Or did you Answer "YES" to any of our COVID 19 screening questions? Yes No
- Do you have a bleeding disorder? Are you taking blood thinners such as Warfarin or Coumadin? Yes No
- Have you been diagnosed with a neurological disorder (eg. Guillain Barre, seizures) or do you experience any numbness, tingling, nerve pain, etc? Yes No
- Are you presently on immunosuppressive therapy (eg. high doses of Corticosteroids or chemotherapy)? Yes No
- Do you have an immunodeficiency disorder (eg. HIV infection, cancer)? Yes No
- 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**. Please also **report this to HEALTHSERV** at 1-866-663-5848.



To be completed by Nurse:

Name of Vaccine: INFLUVAC TETRA Manufacturer: BGP Pharma ULC

Dose: 0.5 ml Expiry: _____ Lot#: _____

Route: IM Deltoid (check one) R or L Immunization Date: _____
DAY/MONTH/YEAR

Nurse: _____