



HEALTHSERV Professionals Inc.

Questionnaire and Consent to receive the Influenza Vaccine

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

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

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Ministry: _____

Worksite Address: _____ City/Town: _____

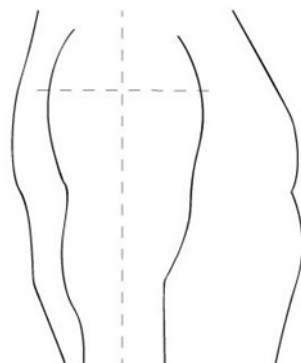
Please check the appropriate answer (all following questions must be answered yes or no):

1. Do you have an anaphylactic reaction to eggs, egg products?
(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
2. Are you allergic to: Formaldehyde, Neomycin Sulphate, Kanamycin, barium Hydrocortisone, cetyltrimethylammonium bromide (CTAB), polysorbate 80? Yes No
3. Other than feeling pain at the injection site, have you ever reacted to a flu immunization or other injection (eg. fainting, visual disturbance)? Yes No
4. Do you presently have an active infection, illness or fever? Yes No
5. Do you have a bleeding disorder? Are you taking blood thinners (Warfarin or Coumadin? Do you have a respiratory illness? Taking theophylline? Yes No
6. Have you been diagnosed with a neurological disorder (eg Guillain Barre, seizures) or do you experience any numbness, tingling, nerve pain, etc? Yes No
7. Are you presently on immunosuppressive therapy (eg. high doses of Corticosteroids, or chemotherapy)? Yes N
8. Do you have an immunodeficiency disorder (eg. HIV infection, cancer)? Yes No
9. 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: AGRIFLU Manufacturer: Seqirus UK Limited

Dose: 0.5 ml **Expiry:** _____ **Lot#:** _____

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

Nurse: _____