



Healthserv Professionals Inc.

Questionnaire and Consent to receive the FLUZONE Trivalent Vaccine

Please complete the questionnaire and bring this form with you to your preferred immunization clinic.

Please wear short sleeves to your immunization appointment.

Your personal information is collected in accordance with sections 26(a)(c) of the Freedom of Information and Protection of Privacy Act and the Healthcare Consent and Care Facilities Act for the purposes of safely administering your influenza vaccine. If you have any questions about the collection or use of this information, please contact Healthserv at 1-866-663-5848 or see our Privacy Policy: <http://www.healthserv.com/privacy-policy/>

First Name: _____ Last Name: _____

Worksite Address: _____ City: _____

Please check your Ministry or Organization:

- | | | |
|---|--|--|
| ☐ Agriculture and Food | ☐ Tourism, Arts, Culture and Sport | ☐ BC Energy Regulator |
| ☐ Attorney General | ☐ Transportation and Transit | ☐ BC Housing |
| ☐ BC Public Service Agency | ☐ Water, Land and Resource Stewardship | ☐ BC Infrastructure Benefits |
| ☐ Children and Family Development | | ☐ BC Investment Management Corporation |
| ☐ Citizen's Services | | ☐ BC Pension Corporation |
| ☐ Corporate Services for the Natural Resource Ministries | ☐ Office of the Premier | ☐ BC Securities Commission |
| ☐ Education and Child Care | ☐ Cabinet Operations | ☐ BC Treaty Commission |
| ☐ Emergency Management and Climate Readiness | ☐ Government Comms and Public Engagement | ☐ BC Utilities Commission |
| ☐ Energy and Climate Solutions | ☐ Intergovernmental Relations Secretariat | ☐ Community Living BC |
| ☐ Environment and Parks | | ☐ Consumer Protection BC |
| ☐ Finance | ☐ Legislative Assembly | ☐ Destination BC Corp. |
| ☐ Forests | ☐ Elections BC | ☐ Environmental Assessment Office |
| ☐ Health | ☐ Office of the Auditor General | ☐ First People's Cultural Council |
| ☐ Housing and Municipal Affairs | ☐ Office of the Conflict of Interest Commissioner | ☐ Forest Practices Board |
| ☐ Indigenous Relations and Reconciliation | ☐ Office of the Human Rights Commissioner | ☐ Habitat Conservation Trust Fund |
| ☐ Jobs, Economic Development and Innovation | ☐ Office of the Information and Privacy Commissioner | ☐ InBC Investment Corporation |
| ☐ Labour | ☐ Office of the Merit Commissioner | ☐ Infrastructure BC |
| ☐ Mining and Critical Minerals | ☐ Office of the Ombudsperson | ☐ Innovate BC |
| ☐ Post-Secondary Education and Future Skills | ☐ Office of the Police Complaint Commissioner | ☐ Royal BC Museum |
| ☐ Public Guardian and Trustee | ☐ Office of the Representative for Children and Youth | ☐ Transportation Investment Corporation |
| ☐ Public Safety and Solicitor General | | ☐ OTHER please specify: _____ |
| ☐ Social Development and Poverty Reduction | | _____ |

FULL NAME: _____

ALL QUESTIONS MUST BE ANSWERED, YES OR NO, BEFORE IMMUNIZATION IS GIVEN.

1. Have you ever had a reaction to influenza immunization or another injection? ☐ Yes ☐ No

2. Are you allergic to, or have ever had a reaction to:

(A reaction being hives, swelling of the mouth or throat, difficulty breathing, changes in blood pressure)

Eggs or egg products or chicken protein? ☐ Yes ☐ No

Formaldehyde ☐ Yes ☐ No

Triton X-100 ☐ Yes ☐ No

Other ☐ Yes ☐ No

4. Do you presently have an active infection, illness or fever? ☐ Yes ☐ No

5. Do you have a bleeding disorder? ☐ Yes ☐ No

6. Have you ever had Gillian Barre syndrome (GBS)? ☐ Yes ☐ No

7. Are you presently taking medication such as Theophylline, Aminophylline,
blood thinners, steroids, or other medications? If yes, please list: ☐ Yes ☐ No

8. Are you presently on immunosuppressive therapy? ☐ Yes ☐ No

9. Are you pregnant? If yes, please indicate trimester: _____ ☐ Yes ☐ No

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 or Registered Nurse:

Manufacturer: Sanofi -FLUZONE Trivalent **Dose:** 0.5 ml **Route:** IM Deltoid

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

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

