ST JOHN OF GOD Health Care

2020 Caregiver Influenza Vaccination Declaration and Consent Form

Name:_____ Employee Number:_____ Date of Birth: ____/____/____

Hospital/Service _____ Department / Ward: _____

Occupational Group:			
☐	Medical	**Are you over 18 years of age?**	**Yes** ☐ No ☐
☐	Nursing	**Are you over 65 years of age?**	**Yes** ☐ No ☐
☐	Laboratory	**Are you a SJGHC Caregiver**	**Yes** ☐ No ☐
☐	Other Clinical Staff	**Are you permanent** ☐ **casual** ☐ **other** ☐	
☐	Non-Clinical		
☐	Volunteer		
☐	Other		

1. **Do you have a severe allergy to eggs?** **Yes** ☐ No ☐
   This would include swelling of the lips or tongue or respiratory distress on ingestion of eggs
2. **Do you have a latex allergy?** **Yes** ☐ No ☐
3. **Are you suffering an acute illness with fever (>38.5°C) at present?** **Yes** ☐ No ☐
   Minor illness with/ without fever does not contraindicate vaccination.
4. **Have you ever had a reaction to the influenza vaccine in the past?** **Yes** ☐ No ☐
   E.g. Allergy, anaphylaxis, rash, hives
5. **Have you ever felt faint or fainted after an injection or giving blood?** **Yes** ☐ No ☐
6. **Do you have a history of Guillain-Barré syndrome?** **Yes** ☐ No ☐

Do you give consent to receive the influenza vaccine?

I understand by giving consent to receiving the influenza vaccine I agree to stay within the immediate vicinity of the health professional for 15 minutes after my vaccination.

☐ **Yes, I consent to receive vaccination**

This facility has a responsibility to ensure the safety of caregivers and patients. I am aware of the potential risks that my non participation in seasonal influenza vaccination may pose. By electing not to receive the vaccine I understand that in the event of an influenza outbreak special infection control requirements may be necessary (e.g. wearing a surgical mask, redeployment).

☐ **No, I choose to decline the vaccination**

If declined, please tick all that apply:

- ☐ **I have had a previous medically confirmed, serious allergic reaction to an influenza vaccine or component of the vaccine**
- ☐ **Other, please specify** _____

Caregiver Signature_____ **Date:**_____

Signature of Vaccinator_____ **Date:** _____

Given by: ☐ **IP&C** ☐ **DNM** ☐ **Other** **Batch Number**_____

Caregiver name_____**Batch Number**_____

○FluQuadri ○Influvac Tetra ○Afluria Quad ○Fluarix Tetra ○Fluzone High-Dose(≥65yrs) ○Fluad(≥65yrs)