VACCINATION CONSENT FORM

Name:_____

D.O.B:_____

Please answer the following questions:

Are you feeling well today?	Yes/No
Have you had any severe reaction following the flu vaccine?	Yes/No
Do you have a severe allergy to anything?	Yes/No
Are you allergic to any medications?	Yes/No
Have you had vaccines in the last month?	Yes/No
Are you pregnant?	Yes/No
Do you have a history of Guillain-Barre Syndrome?	Yes/No
Do you have a disease or treatment which lowers immunity?	Yes/No
Are you Aboriginal and/or Torres Strait Islander?	Yes/No

I understand the above questions, consent to this vaccination and understand that I am required to wait for 10 minutes following the vaccination.

Patients Signature: _____ Date: _____

Doctors Signature: _____ Date: _____