Influenza Clinic Consent Form

University of Manitoba

PLEASE PRINT

Last name:		Given name(s):
Date of birth: (dd/mm/yyyy)		Sex: ☐ Female ☐ Male ☐ Other
Home address:	City/town:	Postal code:
6-digit MHSC number (Manitoba):		9-digit PHIN number (Manitoba):
Out-of-province health number (list province as well):		Telephone (home or cell):
Email:		
University status: ☐ Staff ☐ Student ☐ Both ☐ Neither If student, program and grad yr: ________________		Are you employed by the Winnipeg Regional Health Authority (WRHA)? ☐ No ☐ Yes, site: ______________________________ If "YES", may we share this completed form with WRHA Occupational and Environmental Safety & Health (OESH)? ☐ No ☐ Yes

Please answer the following questions:

			If "Yes", please provide details:
Are you feeling unwell or sick today?	☐ **Yes**	☐ **No**	
Do you have any allergies?	☐ **Yes**	☐ **No**	
Have you experienced a reaction to a vaccine in the past?	☐ **Yes**	☐ **No**	
Do you have a bleeding disorder, or are you taking any medications that affect blood clotting?	☐ **Yes**	☐ **No**	
Do you have any medical conditions or are you taking any medications that can suppress your immune system?	☐ **Yes**	☐ **No**	

I understand the risks and benefits of the influenza vaccine, and I consent to receiving this.	☐ **Yes**	☐ **No**

Signature: ______________________________________ Date:_________________________

It is important to stay 15 minutes after receiving an immunization, in case of a rare allergic reaction or fainting.

Please notify a healthcare provider immediately if you have any symptoms or reactions after receiving the influenza immunization.

Consent obtained by clinician ☐ ____

Vaccine provider:

Vaccine	Manufact.	Lot No./expiry date	Site	Route	Dose	Date	Administered by
Seasonal influenza vaccine (quadrivalent)				**IM**	**0.5 mL**		