GPS ON BAYVIEW

PHONE: 9217 6000 FAX: 9384 2257
ADDRESS: Level 1/20 Bayview Tce,
Claremont WA, 6010

FIRST NAME:	LAST NAME:		
MEDICARE NUMBER:	D.O.B:	SEX:	

FLU VACCINATION

1 PLEASE READ THIS FIRST

Influenza vaccine is a prescription medicine available only under the orders of a registered medical practitioner. For on-site vaccination programs, the registered nurse will give the vaccination following the doctor's instruction.

In accordance, the nurse will advise certain people at high risk of side effects to attend the clinic for vaccination or to discuss vaccination with their regular doctor.

The Flu Vaccine CAN:

- Give you the best chance of protection against the main circulating flu viruses, in the order of 70 – 90 % of those immunised.
- Lower your chance of passing flu on to someone at high medical risk.
- Provide some protection from new strains of flu, which are variants of a previous strain covered by the vaccine.

The Flu Vaccine CANNOT:

- Prevent all colds and coughs (the common cold is not caused by the influenza virus).
- Provide instant immunity. It takes about two weeks.
- Cause influenza. The vaccine does not contain a live virus and so cannot cause an infection.

SIDE EFFECTS:

Most people have no or minimal side effects. The commonest side effects are redness, discomfort or swelling at the injection site for a few days. Some people will get fever, muscle pain and feel a bit unwell for a few days. Very rarely an allergic reaction such as hives, angio-oedema, asthma or systemic anaphylaxis may be triggered, most likely due to egg allergy. Extremely rare is a neurological complication Guillain – Barre Syndrome.

Mild side-effects can be treated with paracetamol. If you are concerned, please don't hesitate to call our practice nurse on: 9217 6000

2 PLEASE ANSWER ALL THESE QUESTIONS CAREFULLY

All information will be treated confidentially.

Are you unwell today?	**YES**	**NO**
Have you received a flu vaccine in the past?	**YES**	**NO**
Have you received a flu vaccine since 1 March this year?	**YES**	**NO**
Have you had anaphylaxis following any vaccination in the past?	**YES**	**NO**
Have you ever had a serious or life-threatening reaction to eggs or egg products (e.g., collapse or requiring adrenaline)?	**YES**	**NO**
Are you allergic to these antibiotics? Neomycin or Polymyxin or Gentamicin	**YES**	**NO**
Women- is there a chance that you are pregnant?	**YES**	**NO**
Are you prone to fainting with injections? (If so, the nurse will observe you closely and may get you to lie down)	**YES**	**NO**
Do you really hate needles? (It is ok, our nurses are very kind, but its good for them to know this in advance)	**YES**	**NO**

Do you have any other concerns or questions? (Please specify below)

3 CONSENT – PLEASE READ AND SIGN

I have read and understood the above information and I consent to receiving a flu vaccine

SIGNED: DATE: / /

4 CLINICAL STAFF USE ONLY

Comments:

☐ No immediate side effects

VACCINE ADMINISTERED:

☐
☐

☐ AT CLINIC
☐ ON SITE
Location:

Initial

SIGNED: DATE: / /