Silverbirch Medical Practice

SEASONAL INFLUENZA CONSENT FORM 2024-2025

SECTION 1: Please complete as much information as possible before attending for vaccination

Patient's Name	Date of Birth	Age
Address: Mobile No: Home No: Email: **Please note it is vital that you update your contact details NOW and if they change.**		Smoking Status (please circle) Never Ex-smoker (quit date) Smoker – How many per day? Smoking is seriously harmful to your health if you would like help stopping please ask
Height	Weight	How many alcohol units per week?
Blood pressure	Blank	Blank

SECTION 2: Please complete on the day of your appointment and BEFORE ARRIVAL at the clinic	**YES**	**NO**
Are you feeling UNWELL today? Do you have a FEVER?		
Are you taking any antibiotics now or in the past week?		
Have you had chemotherapy or steroids in last 3 months? **If yes not Fluenz**		
Do you have any history of immunodeficiency? (leukaemia/lymphoma) **If yes not Fluenz**		
Is your child receiving salicylate therapy such as Aspirin? **If yes not Fluenz**		
Are you a household contact of anyone with severe immune compromise? **If yes – see GP**		
Is your child experiencing an asthma exacerbation or using increased blue inhaler or requiring regular oral steroids or previously been admitted to intensive care? **If yes not Fluenz –see GP**		
Are you currently on methotrexate or other tablets for Arthritis/Psoriasis/Crohns that require blood monitoring? **If yes not Fluenz**		
Are you allergic to eggs / chicken / gentamicin / kanamycin / neomycin / gelatine / latex or had a previous confirmed anaphylactic reaction to a vaccine? **If yes see GP for vaccination**		
Ladies Only: Are you pregnant or breast feeding? **If yes not Live vaccine**		
Have you ever had the pneumococcal vaccine?		
Have you ever had the shingles vaccine?		

SECTION 3: To be completed by Practice Staff

	Batch No & Expiry Date	Vaccination Site
FLU		
Pneumococcal		
Shingles		

I confirm that I give my consent for the influenza vaccination ☐ OTHERS if needed – pneumococcal ☐ shingles ☐

Eligible for shingles: age 65 or 70 on 1 Sept 2024 | age 66 or between 71 and 70 on 1 Sept 2024 and have never received a shingles vaccine | age 80 but received a first dose of shingrix before turning 80 and require a second dose of shingrix to complete the course before 81st birthday

Patient Signature X _____ **Date X** _____

I confirm that I have explained the treatment proposed and the details of the minor side effects of the proposed vaccine.

Staff Signature _____ Date _____

Practice Use Only

Respiratory Disease	Heart Disease	Renal Disease	Diabetes	Chronic Liver Disease	Immunosupp 2ry disease or treatment	Pregnant	Chronic Neuro disease	Morbid Obesity (BMI ≥40)
Other with clinical indication	Carer	Household contact of Shielder	Nursing or Residential Home	Primary school mop up	Over 65	Pre-school children 2-4	Asplenia or Dysfunction of Spleen	