HOMES AND SENIORS SERVICES

INFLUENZA (FLU) VACCINE CONSENT FORM – COUNTY OF ELGIN STAFF

Staff Name: _____Phone Number:_____Age:_____

***Please answer all questions:**

1. a) Have you ever had a flu vaccine? Yes ☐ No ☐
   b) Have you ever had a reaction to the flu vaccine (hives, difficulty breathing?) Yes ☐ No ☐

2. Do you have a fever or feel sick today? Yes ☐ No ☐

3. Have you ever had Guillain-Barré Syndrome (GBS), a disease that causes your muscles to stop working or Oculo-Respiratory Syndrome (ORS)? Yes ☐ No ☐

4. Are you allergic to:
   - thimerosal (mercury) Yes ☐ No ☐
   - neomycin Yes ☐ No ☐
   - kanamycin Yes ☐ No ☐
   - formaldehyde Yes ☐ No ☐
   - eggs /egg products Yes ☐ No ☐

5. Do you have a bleeding disorder (i.e.: hemophilia)? Yes ☐ No ☐

6. Do you have severe asthma or have you seen a doctor for wheezing in the last week? Yes ☐ No ☐

7. Do you take blood thinners (i.e.: aspirin, Coumadin, warfarin)? Yes ☐ No ☐

8. Do you have any problems with your nervous system? (i.e.: multiple sclerosis, migraines, dementia, epilepsy, Parkinson's disease, muscular dystrophy, etc.). Yes ☐ No ☐

9. Are you currently taking a beta-blocker (e.g. acebutolol, propranolol, nadolol)? Yes ☐ No ☐

If you answered "yes" to questions 1b-9, please explain below:

_____

_____

_____

I have read (or it has been read to me) and I understand the Influenza (Flu) Vaccine Information sheet. I have had my questions answered and I consent to receiving the influenza vaccine.
I understand that I cannot receive the vaccine at the County of Elgin Homes if I answer YES to any of the above questions. I understand, however, that I may still be able to get the vaccine and to do so, I should contact my own physician.

Signature: _____ Date: _____

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Personal information on this consent form is collected by law under the Health Protection and Promotion Act and Personal Health Information Protection Act. The information may be used for evaluation or research purposes.

Any questions about the collection of this information should be directed to the Manager of Resident Care of the Home.

Vaccine Name: _____

Lot # of Vaccine: _____

Expiry Date of Vaccine: _____

Dose: _____

Route: _____

Site: _____

Date /Time Vaccinated: _____

RN/RPN signature: _____