POLYCLINIC
FAMILY AND SPECIALTY MEDICINE

2 CHAMPAGNE DRIVE (CHAMPAGNE CENTRE) TORONTO M3J 2C5

TEL: 416-222-6160 FAX: 416-222-9604

Seasonal Influenza Immunization Consent Form
Ages 16 Years and Older

Last Name: _____ First Name: _____

Date of birth: _____/____/____ Age: _____ Gender: **Male** **Female**

Address: Postal code: Phone: ( )

1. Have you ever had a serious reaction to a previous of influenza Vaccine and /or other vaccines? Yes [ ] No [ ]
2. Do you have fever today? Yes [ ] No [ ]
3. Are you allergic to the following products?
   - (a) Formaldehyde? Yes [ ] No [ ]
   - (b) Neomycin? Yes [ ] No [ ]
   - (c) Kanamycin? Yes [ ] No [ ]
   - (d) Thimerosal? Yes [ ] No [ ]
   - (e) Eggs or egg product? Yes [ ] No [ ]

If "yes" to eggs / egg product allergy:

[ ] *mild gastrointestinal reaction after consuming eggs*

[ ] *mild local skin reaction*

[ ] *anaphylactic reaction*

[ ] *positive specific skin/IgE test*

4. Have you ever been diagnosed with Guillain-Barre Syndrome? (*a type of temporary severe muscle weakness*) Yes [ ] No [ ]
5. Do you have a new neurological disorder, bleeding disorder, or history of fainting? Yes [ ] No [ ]

I consent to have Polyclinic Family and Specialty Medicine Facility administer the influenza Vaccine to me. I have read the Influenza Vaccine (Agriflu, Vaxigrip, Fluviral) Fact Sheet provided to me. I have been advised to see my physician if I have any questions concerning the influenza vaccine. I understand the benefits, risks and possible side effects to vaccination.

I will stay at the Polyclinic Family and Specialty Medicine Facility for a minimum of 15 minutes after receiving the influenza vaccine.

If I have an adverse reaction to the vaccine I will go to a physician immediately and contact Polyclinic Family and Specialty Medicine Facility.

Signature of Client:_____ _____ Date:_____/____/____

Signature of Witness_____ Date:_____/____/_____