

Fluenz Patient Consent Form

Personal Details		Date of Birth:_					
Surname:		Phone No:					
Forename:		PPSN:					
Address:		Medical Card No					
		GP:					
Nationality:							
Medical History		1			Y	es	No
Is the patient allergic to ger	or any of the ot	her ingredient	s?				
• Does the patient have a blood disorder or a cancer that affects the immune system?					n?		
 Is the patient taking anticancer drugs, immunosuppressants, blood thinners, or 							
acetylsalicylic acid (aspirin)?							
 Does the patient have severe asthma or is currently wheezing? 							
 Is the patient allergic to eggs or chicken? 							
					-2		
, , , , , , , , , , , , , , , , , , , ,					-		
Is the patient in close contact with someone with a weakened immune system? Share is not recommended for warmen who are present as one breast feeding.							
Fluenz is not recommended for women who are pregnant or are breast-feeding.							
Fluenz is not to be given at the same time as influenza-specific antiviral medicines							
Eligibility Criteria	E - Chronic Liver D	K- Haemoglobir	-				
-please tick if aged >12 -17 years	F – Chronic Neuro	L – Child with re					
A - Chronic Respiratory Disease	G - Immunosuppre	P – Close conta Q – Child on lor	-		'		
B – Pregnancy	I – Diabetes	AL – Down Synd	_	spiriii			
C – Chronic Heart Disease	J – Morbidly Obes	CN – Clinical ne					
D – Chronic Renal Failure							411
The HSE will remunerate for administration of the Live Attenuated Influenza Vaccine (LIAV), i.e. nasal flu vaccine, to all children aged 2- 12 years inclusive, whether at risk or not.							
Consent: I have read and understood the influenza vaccination leaflet and have been given an opportunity to speak to the							
pharmacist providing the Fluenz vaccine. I understand:							
The nature of the treatment.							
The benefits and risks of immunisation.							
The risks of influenza.							
The possible side effects of vaccination, when they might occur and how they should be treated.							
I have been given an opportunity to ask questions and raise any concerns.							
I agree that the details I have supplied have been recorded and those records will be kept by Phelans pharmacy and I consent to							
the administration of adrenaline should the pharmacist deem it to be required in the event of an anaphylac					Ī	action	
			No				
I agree to proceed with the vaccination for Influenza: I require a copy of my vaccination record form to be sent to my GP:			V				
Name and address of GP:			V				
Signature:Date:							