Irish Pharmacy Union
The voice of community pharmacy

HSE PharmaVax Reference Number

PHARMACY STAMP

Influenza Consent & Medical Eligibility

QIV Vaccine

Personal Details

Forename: _____

Surname (Family Name): _____

Gender: Male ❑ Female ❑ Other ❑

Mother's Birth Surname: _____ PPSN: _____

Nationality: _____

Ethnicity (Tick one)

Irish	❑	African	❑	Roma	❑
Irish Traveller	❑	Any other Black Background	❑	Arab	❑
Ukrainian	❑	Chinese	❑	Other (mixed)	❑
Any other white background	❑	Any other Asian Background	❑	Prefer not to say	❑

Contact Details

Email Address: _____

Mobile Phone Number: _____

Eircode/Address: _____

GP Name: _____

GP Address: _____

I agree for a copy of my vaccination record form to be sent to my GP: Yes ❑ No ❑

At-risk categories (tick all that apply)

Aged 65 years and older	❑	BMI >40	❑	Healthcare workers	
Chronic Respiratory Disease	❑	Haemoglobinopathies	❑	- Medical/Dental	❑
Chronic Heart Disease	❑	Condition that can compromise respiratory function	❑	- Nurse	❑
Chronic Renal Failure	❑			- Health and social saff	❑
Chronic Liver Disease	❑	Resident of a nursing home and other long stay institutions	❑	- Management/Admin	❑
Chronic Neurological Disease	❑			- General Support Staff	❑
Immunosuppression due to disease or treatment (including cancer)	❑	Close contact with pigs, poultry, or waterfowl	❑	- Other	❑
				Down Syndrome	❑
Household contacts/out of home carer of people with increased medical risk	❑	On long-term aspirin	❑	Pregnancy	❑
		Moderate to severe neurodevelopmental disorder	❑		
Diabetes Mellitus	❑				

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Medical History	Yes	No
• Is the patient 6 months of age or older?	❑	❑
• If aged 2-8 is this their first time ever receiving the flu vaccine?	❑	❑
• Are you pregnant?	❑	❑
• Are you at risk of lymphoedema in any limb?	❑	❑
• Do you feel unwell in any way?	❑	❑
• Have you ever had a severe allergic reaction to anything including eggs, chicken, medication or vaccines (including vaccine excipients)?	❑	❑
• Have you ever had an anaphylactic reaction to eggs or chicken requiring ICU admission?	❑	❑
• Are you taking combination checkpoint inhibitors?	❑	❑
• Are you post haematopoeitic stem cell or solid organ transplant and receiving influenza vaccine for the first time post-transplant?	❑	❑
• Have you completed chemotherapy for cancer since September 2023?	❑	❑
• Do you have severe neutropenia (low levels of a type of white blood cell) i.e. absolute neutrophil count <0.5 × 109/L.?	❑	❑
• Do you have a condition/take any medication that increases your risk of bleeding?	❑	❑
• Is this your first time receiving the flu vaccine this season?	❑	❑
• Please list any current medical conditions, medications or allergies: _____		

Consent:

I have read and understood the influenza vaccination leaflet and have been given an opportunity to speak to the pharmacist providing the vaccine to ask questions and raise any concerns. I understand who may receive a free flu vaccination under the national immunisation campaign. The details I have provided are accurate and I understand that those details have been recorded by the pharmacy and will be kept by the pharmacy for 8 years and shared with the HSE for the purposes of public health as required by legislation. Any data collected will be processed in accordance with relevant data protection requirements. I consent to receiving the 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.

Signature of person providing consent: _____

Name of parent/guardian/ legal representative when signed on behalf of patient E.g under 16 years of age _____

Pharmacist section:

This young person assents to vaccination Yes ❑ No ❑
Consent was implied through interaction with the patient Yes ❑ No ❑

Pharmacists Signature _____

QIV Vaccine

Date Given	Vaccine Name & Manufacturer	Batch Number	HSE Funded	Expiry Date Month/Year	Site of Vaccination	Name of Vaccinator (please print) and PSI number
___ /___ /_____			Yes ❑ No ❑		L Deltoid ❑ R Deltoid ❑ Other	

I confirm that the information collected on this form has been added to HSE PharmaVax and the patients GP has been notified where indicated (tick box) ❑

Name: _____