TORONTO Public Health

Vaccine Preventable Diseases Program

# 2023–2024 INFLUENZA VACCINE CONSENT FORM

## 1. Client Information

| Client's Last Name | | | Client's First Name |
|---|---|---|---|
| Birthday Year | Month | Day | Sex ☐ Male ☐ Female ☐ Self-identify:_____ |
| Address | | | Postal Code |
| Name of Parent / Legal Guardian (for child) | | | Relationship to Child |
| Cell / Home Phone | | | |

## 2. Health Assessment

| | | |
|---|---|---|
| a) Have you (or child) been sick recently or had a fever? | ☐ **Yes** | ☐ **No** |
| b) Have you (or child) had a serious reaction to a vaccine before? | ☐ **Yes** | ☐ **No** |
| c) Do you (or child) have any allergies (e.g.Thimerosal, Neomycin, Polymyxin B, Kanamycin)? | ☐ **Yes** | ☐ **No** |
| d) Have you (or child) been diagnosed with Guillain-Barré or Oculo-Respiratory Syndrome? | ☐ **Yes** | ☐ **No** |
| e) Do you (or child) have a neurological or bleeding disorder, or a history of fainting? | ☐ **Yes** | ☐ **No** |
| f) Have you received a vaccine in the past 14 days? | ☐ **Yes** | ☐ **No** |

## 3. Consent for Vaccination

Clients, 14 years and older can sign their own consent

I have read the attached influenza vaccine fact sheet. I understand the expected benefits and possible risks and side effects of the vaccine. I understand the possible risks to myself / my child if not vaccinated. I have had the opportunity to have my questions answered by Toronto Public Health.

**I authorize Toronto Public Health to administer the influenza vaccine to myself / my child.**

X _____ _____

Signature of Client ☐ Parent/Legal Guardian ☐ Date

## 4. Nurse to Complete

| Influenza Vaccine IM Injection<br>Vaccine Administered: | | | Dose: | Lot #: | Expiry Date: | Indicate Vaccination Site | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Deltoid | | Anterolateral Thigh (infant only) | |
| | | | | | | Left | Right | Left | Right |
| | ☐ | FluLaval Tetra® QIV (6 months and older) | 0.5 mL | | | ☐ | ☐ | ☐ | ☐ |
| | ☐ | Fluzone® QIV (6 months and older) | 0.5 mL | | | ☐ | ☐ | ☐ | ☐ |
| 65+ Only | ☐ | Fluzone® HD-QIV | 0.7 mL | | | ☐ | ☐ | N/A | N/A |
| | ☐ | Fluad® Adjuvanted-TIV | 0.5 mL | | | ☐ | ☐ | N/A | N/A |
| Vaccinator's Name: | | | | | | | | | |
| Vaccinator's Signature: | | | | | | | Date & Time: | | |
| Notes: | | | | | | | | | |

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act. It is used to administer the TPH Vaccine Preventable Diseases (VPD) Program, including maintaining immunization records for students. For more information, visit our Toronto Public Health Information Practices Statement at https://www.toronto.ca/community-people/health-wellness-care/information-practices-statement/ or contact 416-338-7600.