TMVC
TRAVEL MEDICINE & VACCINATION CENTRE

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Health Profile for Recipients of Seasonal Influenza Vaccine

Last Name: _____ First Name: _____

Birth Date: (d) _____ (m) _____ (y) _____ Age: _____ PHN: _____

Telephone: (H) _____ (W) _____ Address: _____

Do any of the following apply to you?	**Yes**	**No**
Is this the first time you will be receiving a flu vaccine?		
Have you ever had a severe reaction to immunization?		
Do you have a history of an anaphylactic (severe allergic) reaction to Eggs or Egg Products? Any severe allergies? If yes, please list:		
Have you ever had Severe Oculo-Respiratory Syndrome (ORS) after getting a flu shot?		
Have you ever fainted from having an injection?		
Have you ever been diagnosed with Guillain-Barré Syndrome?		
Are you currently taking any medication, or have you any chronic-ongoing medical problems (include past cancer history, i.e. mastectomy)? If yes, please explain:		
Are you pregnant? Note: BCCDC recommends all pregnant women to receive the inactivated flu shot during the flu season		
Have you had a fever or illness within the last 24 hours?		
If receiving the Tetanus Diphtheria vaccine in addition to the influenza vaccine, please indicate date of previous dose(s)	Date:	

The seasonal flu vaccine is generally well tolerated; however, you may experience slight soreness and redness at the injection site that should not interfere with daily activities. Other less common side effects could include a mild fever and muscle aches within 6-12 hours after vaccination; this may last for 1-2 days, Acetaminophen (Tylenol) is recommended for these symptoms.

Vaccination is not 100% protective. Protect yourself by both washing your hands often with soap and water, and avoiding contact with ill people. The flu virus can survive for a number of days on surfaces or objects that an infected person touches.

As with any vaccine there is the rare possibility of an anaphylactic reaction (severe allergic reaction) occurring. This can include hives, wheezy breathing or swelling of any part of the body, throat or face. If any of these symptoms occur, please seek the immediate attention of a physician or the nearest hospital emergency department.

My signature below signifies that I have read and understand the information provided to me concerning the influenza vaccine including the risks and benefits. I have had the opportunity to have my questions answered and hereby give my consent to receive the vaccine. In addition, I give my permission to the Travel Medicine and Vaccination Centre to inform my Employer or Family Physician (if so requested) of the administration of the influenza vaccine.

SIGNATURE:_____**DATE:** _____

For Office Use Only ***Circle vaccine type, write lot #, circle site of administration, date and sign***

PAID: Agriflu/Afluria (multi/single) ***Dose & Route:*** 0.5 mL IM **Lot#**:_____Site: **L / R del**

PH:_____ (multi/single) ***Dose & Route:*** 0.5 mL IM **Lot#**:_____Site: **L / R del**

Date: _____Nurse *Signature*: _____MSP / Cash / Debit / Credit / Invoice

Td Vaccine Given, Dose & Route: _____ *Lot #:* _____ Site: **L or R del**