NON MEDICARE CARD HOLDERS ONLY
Influenza Immunization Questionnaire & Consent

The following questions are to assess any contraindications for receiving the Influenza Vaccine. Please read each question carefully and check YES or NO as appropriate. If you answer yes to any question, we will be unable to give you the vaccine, unless you have permission by your health care provider.

BEFORE CONSENTING TO RECEIVING THE INFLUENZA VACCINATION, PLEASE ANSWER THE FOLLOWING QUESTIONS. THE INFORMATIONS YOU PROVIDE IS PRIVATE AND CONFIDENTAIL AND WILL NOT BE USED FOR ANY OTHER PURPOSE.

ARE YOU TAKING ANY MEDICATION **YES / NO TYPE……**
(Please speak to you local Doctor if you are taking any medication (please phone)

If you are taking medication has the Doctor cleared you to receive the vaccination? **YES / NO**
Name of Doctor…….Ph……..

1. Have you ever had a severe reaction to a Flu Vaccine previously? **YES NO**
2. Are you sensitive to eggs, chicken feathers or chicken dander? **YES NO**
3. Do you have a history of sulfite sensitivity (food preservative-not sulfa)? **YES NO**
4. Have you had an allergic reaction to thimerosal (mercury derivative)? **YES NO**
5. Do you presently have an acute respiratory illness or active infection WITH a fever? **YES NO**
6. Are you receiving therapy with ACTH, Corticosteroid, Radiation, Antimetabolites or Immuno suppressants? **YES NO**

7. Are you taking any of the following medications: Theophylline, Phenobarbital, Dilantin, Coumadin? **YES NO**

If yes, you must provide written permission from your physician. **YES NO**

8. Do you have a history of febrile convulsions? **YES NO**
9. Do you have a history of Guillain-Barre' Syndrome (GBS)? **YES NO**
10. Have you had a LIVE Virus Vaccine within the last month? **YES NO**
11. If female, are you pregnant or suspect you may be? **YES NO**

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I have answered the above questions honestly and have had an opportunity to ask questions. I understand the benefits and risks of the Flu Vaccine as described. I understand that I cannot get the 'flu' from this vaccination. I voluntarily consent to receive
the Vaccine formulated for the current season and release Capital Health Care Pty Ltd from any and all responsibility for this immunization. I will report any adverse reactions to my physician.

PLEASE PRINT NAME: _____ DATE: _____
SIGNATURE: _____

Vaccine Sticker