Influenza Vaccination
Risk Assessment and Consent

Company:	
Name:	
Date of Birth:	
Address:	

Employee to complete: -

Please tick appropriate column: -	**Yes**	**No**
Are you well today (e.g. no fever)?		
Have you ever had any allergic reactions to medicines, foods (eggs), or vaccinations?		
Are you taking any medication? If yes please list medication:		
Have you had any of the following symptoms in the last 10 days: • **a high temperature** – this means you feel hot to touch on your chest or back (you do not need to measure your temperature) • **a new, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual) • **a loss or change to your sense of smell or taste** – this means you have noticed you cannot smell or taste anything, or things smell or taste different to normal		

Employee Consent:
I confirm that the responses are true to the best of my knowledge and hereby give my consent for the OHN to administer influenza vaccine.
Signed by employee:

OHA to complete: -

Anaphylaxis Risk Assessment	**YES**	**NO**
Has the patient received an influenza vaccine previously without complication?		
If no, was it associated with an anaphylactic reaction?		
Patient information leaflet given to employee?		

Vaccination site Left Deltoid ☐ Right deltoid ☐

Name of Nurse:	Signature:	Date: