Pharmacy Influenza Vaccination Patient Consent Form

This form should be tailored to reflect processes in your pharmacy and the relevant guidelines and vaccination SPCs and should be used in conjunction with the PCRS Vaccination Record form

Personal Details	Date of Birth:_____
Surname:_____	Phone No:_____
Forename:_____	Gender:_____
Address:_____	PPSN:_____
_____	GP:_____

Medical History	**Yes**	**No**
• Are you under the age of 18?		
• Are you pregnant?		
• Have you had breast surgery?		
• Do you feel unwell in any way?		
• Are you allergic to eggs or chicken?		
• Have you ever had an allergic reaction to any previous vaccination?		
• Are you allergic to any of the vaccine residues or excipients?		
• Have you ever suffered an anaphylaxis attack?		

• Please list any current medical conditions, medications or allergies:

_____

Vaccination Details

Vaccine Name:_____

Date of Administration:_____ Injection Site:_____

Vaccine Dosage:_____ Batch Number:_____

Marketing Authorisation Number: _____ Expiry Date:_____

Consent: I have read and understood the influenza vaccination leaflet and have been given an opportunity to speak to the pharmacist providing 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.

I have been given an opportunity to ask questions and raise any concerns.

I agree that the details I have supplied have been recorded and those records will be kept by _____ pharmacy.

	Yes	**No**
I agree to proceed with the vaccination for Influenza:		
I agree for a copy of my vaccination record form to be sent to my GP:		

Signature:_____ Date:_____