healthSAVE Wilkinson's Pharmacy Open 7 days 9am - 9pm

14 Wilson St Burnie TAS 7320 Ph. (03) 64311233 Fax (03) 64317083

INFLUENZA VACCINATION SCREENING 2020

Name: ..... Address: .... Phone:..... Medicare Number: ..... Date of Birth: ..... *(Influenza vaccination is only available for customers aged 10 years and over)*	Dispensing Label AFFIX LABEL HERE

Have you ever had an influenza vaccination before? Yes No (Please circle)

GENERAL HEALTH AND SUITABILITY FOR VACCINATION -Please tick any statements that apply to you:

YES NO

- ☐ ☐ You are unwell today
- ☐ ☐ You have a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone or prednisolone, radiotherapy, chemotherapy)
- ☐ ☐ You have had a severe reaction following any vaccine
- ☐ ☐ You have any severe allergies to anything
- ☐ ☐ You have a history of Guillain-Barre syndrome
- ☐ ☐ You have a bleeding disorder
- ☐ ☐ You have an occupation or lifestyle factor(s) for which vaccination may be needed
- ☐ ☐ You have had an injection of immunoglobulin, or have received any blood products within the past year.
- ☐ ☐ You have an egg allergy
- ☐ ☐ You are prone to fainting
- ☐ ☐ You are pregnant
- ☐ ☐ You have a chronic illness
- ☐ ☐ You are of Aboriginal or Torres Strait Islander descent
- ☐ ☐ You are older than 65 years of age

PHARMACY USE
Brand:
Batch:
Expiry
Time:
Site:
Pharmacist:
Paid Yes/No

CONSENT

- I have been provided with, read and understood information regarding the possible side effects of the vaccine, and if I have any further questions, I will ask the immuniser prior to being vaccinated.
- I request to have the influenza vaccine and understand that it is completely voluntary.
- I have been informed of, and agree to pay, the fees or charges associated with this service.
- I agree to remain in the pharmacy for 15 minutes following vaccination to enable the provision of medical assistance or treatment if required.
- I consent to the provision of emergency care if required, and authorise the pharmacy or service provider to access medical care on my behalf as required. I understand that I am responsible for any cost associated with any emergency care that may be provided.
- I consent to have details of this vaccination recorded on Australian Immunisation Register.

Consumer/Guardian Signature:.....Date:.....