The Bridge Family Practice & Skin Clinic
Shop 1-4/10 Old Coast Road
Halls Head, W.A., 6210
08 9582 4999

Ravenswood Family Practice
4/60 Lloyd Avenue,
Ravenswood, W.A., 6208
08 9582 4998

CONSENT FORM

Influenza Immunisation 2020

The following consent form is to be read in its entirety and completed, where possible, PRIOR to attendance at the medical centre.

In lieu of the current COVID-19 outbreak, please note the following advice regarding our immunisation process.

You will be required to book a specific appointment to receive the influenza vaccination. We ask that you DO NOT ATTEND IF YOU ARE UNWELL. Please only arrive on your specific appointment time (and not earlier) and present to reception. You will be subject to a temperature check prior to proceeding. You will need to allow 15 minutes to wait in your car after your vaccination, in case you have a reaction. This is so we can easily access you to provide treatment. If the clinic is busy, you will need to help us ensure social distancing is met.

It is not possible to get the flu from getting the flu shot. The vaccine contains particles of killed viruses, so it cannot cause influenza. Some people can experience side effects from the vaccine, which include:

- pain, redness and swelling at the injection site,
- low grade temperature,
- muscle aches, and/or,
- drowsiness.

There are no standard contraindications to receiving the influenza vaccination, however extra precautions will be taken in the event of current illness or fever, anaphylaxis to egg or previous Guillain-Barre Syndrome patients.

By signing below,

I, ____ DOB, ___________________ (Age:_______)

give my **Consent** to receiving the recommended dose of the 2020 Influenza Immunisation from:

(Practice Name) ____

I elect to: *(Please select an option below)*

☐ WAIT – as recommended. This will be local to the premises as directed, for a period of at least 15 minutes following the immunisation. If I have any adverse events following immunisation, I will need to present to the staff for treatment.

☐ LEAVE - I understand and accept the risks of leaving the premises prior to this, which may include anaphylaxis or significant injection site reactions.

……………………………………..	……………………………………	……………………………………
Signature of Patient /Guardian	Nurse / GP Signature	Date

Vaccination given:	Batch/Expiry:	Location of injection (deltoid): LEFT / RIGHT