Irish Pharmacy Union
The voice of community pharmacy

Pharmacy reference number

Pharmacy Influenza aQIV / QIV Vaccination Patient Consent Form

Personal Details

Surname: ____________________ Phone No: ____________________

Forename: ____________________ Gender: ____________________

Address: ____________________ PPSN: ____________________

____________________ GP Name: ____________________

Date of Birth: ____________________ GP Address: ____________________

Medical History

Medical History	Yes	No
• Is the patient 6 months of age or older?	❑	❑
• If under 9 years old, have they had the vaccine before?	❑	❑
• Are you 65 years or older?	❑	❑
• 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: ____________________	❑	❑

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 and shared with the HSE for the purposes of public health as required by legislation.

	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:	❑	❑

Signed by the pharmacist on behalf of the patient

Signature: ____________________ Date: ____________________

For under 16's, Name of Parent/Guardian ____________________

Vaccination Details

Vaccine Name: ____________________ Injection Site: ____________________

Date of Administration: ____________________ Batch Number: ____________________

Vaccine Dosage: ____________________ Expiry Date: ____________________

Marketing Authorisation Number: ____________________ PSI number: ____________________

Vaccinating pharmacists name: ____________________ HSE funded vaccine ❑ Private vaccine ❑