Influenza Vaccination Questionnaire and Consent – External Client

Name:			
Address:			
Postcode:		Identifies as an Aboriginal or Torres Strait Islander	☐ Yes ☐ No
Dte of Birth:	/ /	☐ Male ☐ Female ☐ Indeterminate	
Contact Phone Number:			
Medicare Number – (AIR Registration)			
Employer / Department			
Employment Status		☐ FT ☐ PT ☐ Cas ☐ Other	

Important Information

- The Influenza vaccine is generally well tolerated
- Occasional discomfort, redness and swelling at the injection site is the most common adverse reaction
- Fever, muscle pain and generally feeling unwell may occur within a few hours of vaccination and could last 1-2 days
- Immediate adverse events such as hives, angio-oedema, asthma or systemic anaphylaxis are a rare consequence of vaccination
- Guillain – Barre syndrome is rarely associated with influenza vaccination (1 in 2 million), although a direct relationship has not been established
- You are advised to remain in the observation area for a minimum of 15 minutes.
- **Adults aged 65 years and over are advised the adjuvanted influenza vaccine (Fluad Quad) is recommended in preference to standard QIVs available free through your GP.**

Current Health Status / Suitability

Before receiving Influenza vaccine, please answer the following questions. The information you provide is private and confidential and will not be used for any other purpose.

1.	Are you 65yrs and over?	☐ Yes ☐ No
2.	Do you have an acute feverish illness at present?	☐ Yes ☐ No
3.	Have you been been vaccinated against Influenza?	☐ Yes ☐ No
4.	Have you had a COVID vaccination?	☐ Yes ☐ No
5.	Have you experienced any significant problems after any vaccinations in the past?	☐ Yes ☐ No
6.	Have you previously had Guillain – Barre Syndrome?	☐ Yes ☐ No
7.	Are you allergic to eggs or egg products?	☐ Yes ☐ No
8.	Have you had any severe allergies (to anything) in the past? If Yes please list:	☐ Yes ☐ No
9.	Do you have any medical conditions? If Yes please list:	☐ Yes ☐ No
10	Are you currently taking any medication? If Yes please list:	☐ Yes ☐ No

Privacy Statement

- Ozcare (we, us or our) is committed to the National Privacy Principles contained in the *Privacy Act 1988* (Cth). The purpose of this statement is to advise you that we may collect, use and disclose various personal information about you (that is, information that can identify you) for the purposes of providing services to you, facilitating our internal business operations, including the fulfilment of any legal and regulatory requirements and providing you with information about us and the services that we offer
- We may disclose personal information about you to your nominated next of kin in an emergency involving you, our related entities and affiliated organisations and service providers, who assist us in operating our business
- If the personal information you provide to us is incomplete or inaccurate, we may be unable to provide you with the services you are seeking. Also, if we provide you with in-home care, we may leave your record of treatment with Ozcare, which includes personal information, at your home. You acknowledge that you will keep the record safe and secure and that you will inform us if any event or threatened event jeopardises the safety and security of this record
- You may access the personal information we hold about you in accordance with our privacy policy
- If you wish to access any personal information you will need to put your request in writing to:
  Ozcare, Privacy Officer, PO Box 912, FORTITUDE VALLEY QLD 4006

I have read and understand this information and consent to receiving an Influenza Vaccine injection.
I am aware my details, including my vaccination status, will be forwarded for inclusion in the electronic Australian Immunisation Register (AIR).

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Signature: (Client / Carer / Parent / Guardian)		**Date:**	/ /

OFFICE USE ONLY

- ☐ Confirmed consent has been obtained from the participant
- ☐ Has the Client read the Privacy Statement or
- ☐ Has the Privacy Statement been read to the Client / Representative

Participant Name:			
Vaccine Name:			
Time Given:		Left Arm: ☐	Right Arm: ☐
Vaccine Given By:			
Designation:			
Signature:		Date Given:	/ /
Batch Number:		Vaccine Expiry Date:	/ /

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