Influenza Immunization Consent

First Name: _____ Last Name: _____ (M / F)

Birth Date: _____ Age: _____ Health Card #_____
Year/Month/Day

Phone #:_____ Allergies: No ☐ Yes ☐ _____

I consent to the NWHU sharing this record with my family physician Yes ☐ No ☐
Name of Doctor: : _____

I, (please print) _____, as the parent/legal guardian, of the above named child consent to the vaccination of my child and I confirm that I have legal authority to grant such consent. By signing this form, I also agree that this consent is uncontested by any other legal guardian entitled to provide his or own consent.

Signature _____ **Date** _____

Personal information is collected under the authority of the Health Protection and Promotion Act and related legislation and in accordance with the Personal Health Information Protection Act and/or the (Municipal) Freedom of Information and Protection of Privacy Act. We collect only the personal information needed to provide public health programs and to plan and evaluate our services. Your information may be shared with others as required or permitted by law. For more information contact the health unit at 800-830-5978 or see the privacy statement on our web-site at www.nwhu.on.ca.

For Nurse's Use Only

Dose 1

Vaccine _____(0.5ml)

IM Lot # _____

Right/Left
Deltoid/thigh _____
Date Time

Dose 2 (If needed)

Vaccine _____(0.5ml)

IM Lot # _____

Right/Left
Deltoid/thigh _____
Date Time

Information about influenza disease and vaccine risks and benefits has been provided. The person giving consent has had a chance to ask questions and states satisfaction with and understanding of the information received.

Nurse Signature _____ Nurse Signature _____

Northwestern Health Unit
www.nwhu.on.ca

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