HUMBER

UNIVERSITY OF GUELPH HUMBER

HUMBER COLLEGE & UNIVERSITY OF GUELPH-HUMBER
INFLUENZA VACCINATION-2020

PERSONAL INFORMATION

Last Name: ………………………………………………………………….. First Name (s): …………………………………………………………………

Date of Birth: .... (DD/MM/YY)

Address: ……

Tel. #..Email: …………………………………………………………………………

Student # ……………………………………………………………… Program ………………………………………………………………

INFLUENZA VACCINATION QUESTIONNAIRE

1. Did you have a flu shot last year? Yes ☐ No ☐
2. Have you ever had a reaction to any vaccines in the past? Yes ☐ No ☐
3. Did you ever have red eyes, wheezing or chest tightness within 2-24 hours of getting the flu vaccine? Yes ☐ No ☐
4. Did you get medical attention for the above symptoms? Yes ☐ No ☐
5. Have you read and understood the Influenza Fact Sheet? Yes ☐ No ☐
6. Do you know how you can get influenza? Yes ☐ No ☐
7. Do you understand the benefits of receiving the vaccine? Yes ☐ No ☐
8. Do you know the types of side effects that you might experience after receiving this vaccine? Yes ☐ No ☐
9. Are you hypersensitive/allergic to:
   a. Eggs/chicken proteins Yes ☐ No ☐
   b. Neomycin/Kanamycin Yes ☐ No ☐
   c. Preservatives (cetyl-tri-methyl-ammonium bromide-(**CTAB**) or formaldehyde Yes ☐ No ☐
10. Do you have a fever/illness or infection **today**? Yes ☐ No ☐
11. Have you ever been diagnosed with Guillain Barre Syndrome? Yes ☐ No ☐
12. Are you presently pregnant or breastfeeding? Yes ☐ No ☐

I have received and reviewed the information provided by the Humber College Nursing Staff about Influenza Vaccine. I understand the expected benefits, the material risks and side effects of the vaccine and the likely consequences if I am not vaccinated against Influenza. I agree to notify Humber College Nursing Staff if I have received Influenza Vaccine from another source in the past. I have been informed of the importance of immediately reporting to a Physician any adverse reaction to the vaccine that I may have and understand that if I require additional information on this and other vaccines, I can call the Immunization Infoline at 416-392-1250.

I consent to having one (1) dose of the Influenza Vaccine: **Signature: …………………………………………….Date: ……………………**

FOR CLINIC USE ONLY

Vaccine: FluLaval/FluZone Date: Lot#: Exp. Date: Time:

Rt. Deltoid/Lt. Deltoid Route: IM Dosage: 0.5ml

Dosing Nurse: