

Vaccination consent form

**for people receiving Inactivated Influenza Vaccine (IIV)
or Adjuvanted Inactivated Influenza Vaccine (aIIV)**

IIIV - Vaxigrip or Influvac Sub-unit

allV - Fluid

Please Note: The adjuvanted inactivated influenza vaccine (aIIV), Fluad, is only recommended for those aged 65 years and older. Fluad should not be given to anyone aged less than 65 years.

Please complete the details in Parts 1-3 of this consent form in block capitals and return it to your vaccinator.

Part 1: Personal Details

[illegible]

Surname (Family Name):

Otherwise Known As:

Personal Public Service Number (PPSN):

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Date of Birth:

D	D	M	M	Y	Y	Y	Y

Address:

[illegible][illegible]

Mother's Surname at Birth (Maiden Name):

Is this person a: Healthcare Worker (HCW) ☐ Long Term Residential Care - Resident ☐ Other ☐

Email*:

Mobile Phone Number*:

[illegible]

Ethnic or Cultural Background:

A. White

A.1 ☐ Irish

A.2 ☐ Irish Traveller

A.3 ☐ Roma

A.4 ☐ Any other White background

B. Black or Black Irish

B.1 ☐ African

B.2 ☐ Any other Black background

C. Asian or Asian Irish

C.1 ☐ Chinese

C.2 ☐ Indian/Pakistani/Bangladeshi

C.3 ☐ Any other Asian background

D. Other, including mixed background

D.1 ☐ Arab

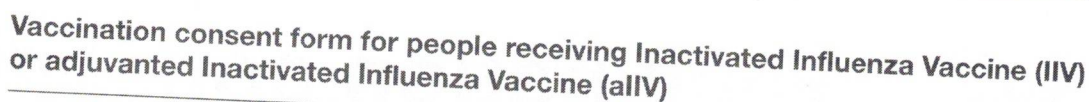
D.2 ☐ Mixed, write in description

Description _____

D.3 ☐ Other, write in description
Description

E. Prefer not to say ☐

**If a child under 16 years of age is being vaccinated, parent/legal guardian details should be provided for email and phone number.*



For people aged 16 years and older*

**Please note that option 4 is only applicable for those aged 18 years and older.*

Please select one of the options and continue to the signature below

- | | |
|---|--------------------------|
| 1. I have/The person has been provided with information that I/they can understand and have/has consented to vaccination with an influenza vaccine. | ☐ |
| 2. I do not/The person does not consent to vaccination with the influenza vaccine and should not be vaccinated. | ☐ |
| 3. The person lacks capacity to decide about influenza vaccination. Vaccination does not conflict with their known will and preference, and they are being vaccinated with the influenza vaccine for their benefit, and as a healthcare professional I confirm that the decision to vaccinate (including any consultations) is documented in the person's healthcare record. | ☐ |
| 4. Consent for influenza vaccination for the person has been given under a decision support arrangement of the Assisted Decision-Making (Capacity) Act 2015 ¹ . Vaccination does not conflict with the person's known will and preference. As a healthcare professional I confirm that the details of the decision support arrangement (including any consultations) are documented in the person's healthcare record. | ☐ |

¹Relevant arrangements: Consent from the person jointly with their co-decision maker or consent by a decision making representative or designated healthcare representative with that authority.

Name (Please print)

Signature:

Date:

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D D M M Y Y Y Y

Please tick to indicate who has completed vaccination consent.

- ☐ Self
- ☐ Healthcare professional
- ☐ Person with co-decision maker under the Assisted Decision-Making (Capacity) Act 2015
- ☐ Decision making representative with that authority under a decision support arrangement under the Assisted Decision-Making (Capacity) Act 2015

For people aged 15 years and younger

Medical Consent: Please note only a parent or legal guardian can provide consent for a medical procedure, or refuse consent for a medical procedure for children under 16 years of age. Young people aged 16 years or older are legally entitled to consent for themselves. Read more about the HSE Consent Policy on the HSE website.

By signing the below I confirm that:

1. I am authorised to give consent on behalf of the above named child/young person.
 2. I understand that I am giving consent for the administration of a dose of influenza vaccine.
 3. I have read and understand the accompanying vaccine information, including known side effects.
- Name (Please print)

Name (Please print)

Signature:

(Please tick)

Parent ☐Legal Guardian ☐

Date:

This child/young person assents to receiving the vaccine (Please tick) ☐

Privacy Statement: The HSE process personal information for all children in the state in relation to the national vaccination programmes such as when vaccines were received or the choice to refuse a vaccine. This data is processed based on the HSE's statutory authority to provide health services to the public. The data will be used as part of individual health records and also to manage and monitor the vaccination programme. Data may be shared between healthcare services. The HSE Privacy Notice for Patients and Service Users explains how we collect and use personal information and is accessible via the HSE Privacy Statement on the HSE website www2.hse.ie/privacy-statement



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The Immunisation Team may need to contact you to discuss details provided in this form. Please note, we may send you an appointment confirmation and/or reminders by SMS and/or email.

Part 3: Medical Details

Please answer the following questions about the person being offered vaccination with a yes or no answer

1. Has this person ever had anaphylaxis (severe allergic reaction) following a previous dose of influenza vaccine or any of its constituents? Yes ☐ No ☐
If yes, ineligible for vaccination as anaphylaxis following a previous dose of influenza vaccine or any of its constituents is a contraindication to vaccination.
2. Has this person ever required admission to ICU for a previous severe anaphylaxis to egg? Yes ☐ No ☐
If yes, go to question 2a. if no, go to question 3.
2a. Has this person had a specialist assessment regarding their severe egg allergy in the past requiring ICU admission and are now recommended the influenza vaccine? Yes ☐ No ☐
If no, they cannot be vaccinated today.
3. Is this person suffering from an acute febrile illness? Yes ☐ No ☐
If yes, they cannot get this vaccine today, defer vaccination until recovery.
4. Is this person on combination checkpoint inhibitors such as ipilimumab or nivolumab? Yes ☐ No ☐
If yes, they may not be able to have the vaccine. This should be discussed with their treating specialist.
5. Does this person have severe neutropenia (low levels of a type of white blood cell) i.e. absolute neutrophil count $<0.5 \times 10^9/L$? Yes ☐ No ☐
If yes, they may not be able to have the vaccine or may need to defer vaccination. This should be discussed with their doctor/treating specialist.
6. Is this the first time this person is receiving the influenza vaccine this season (September to April)? Yes ☐ No ☐
If yes, go to Question 7. If no, and the person is receiving IIV, please answer question 6a.
6a. Does the person receiving the vaccine fit any of the following criteria: Yes ☐ No ☐
 - For children, are they aged 6 months to 8 years and receiving influenza vaccine for the first time
 - Post haematopoietic stem cell transplant or post solid organ transplant and receiving IIV for the first time post transplant
 - Person with cancer who received the first dose of IIV while on chemotherapy in this influenza season and who completed their treatment in the same influenza season (September to April).**If yes, they can receive a second dose of IIV this season, at least 4 weeks after their first dose (and at least 4 weeks after completion of treatment for patients completing cancer treatment). If no, they do not require a second dose of IIV. Please note: For all those aged 65 years and older, only one dose of aIIV is recommended per influenza season.**
7. Does this person have any illness or condition that increases their risk of bleeding? Yes ☐ No ☐
Individuals with a bleeding disorder or receiving anticoagulant therapy may develop haematomas in intramuscular (IM) injection sites. Prior to vaccination, inform the recipient about this risk. For those with thrombocytopenia (platelet count $<50 \times 10^9$), consult the supervising consultant.
8. Is this person a child aged 12-23 months who has received a PCV vaccine within the last week? Yes ☐ No ☐
If yes, then defer influenza vaccination by at least one week from the PCV vaccine.

Vaccination may proceed if no issues for further investigation, deferral or contraindications are noted in the above questions

Thank you for completing the consent form. Please return it to your vaccinator.



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FOR OFFICE USE ONLY

**Please Note: The adjuvanted inactivated influenza vaccine (aIIV),
Fluad, is only recommended for those aged 65 years and older.
Fluad should not be given to anyone aged less than 65 years.**

IIV - Vaxigrip or Influvac Sub-unit

Prescriber's signature and MCRN/PIN	Vaccinator's signature and MCRN/PIN	Product Name	Batch No.	Expiry Date	Date Given																								
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M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y																
Vaccination Site	Right deltoid ☐ or Right vastus lateralis in the anterolateral thigh ☐ Left deltoid ☐ or Left vastus lateralis in the anterolateral thigh ☐																												

aIIV - Fluad (Only recommended for those aged 65 years and older)

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M	M	Y	Y	Y	Y	D	D	M	M	Y	Y	Y	Y																
Vaccination Site	Right deltoid ☐ Left deltoid ☐																												

Completed by: _____ MCRN/PIN: _____
If vaccine not administered please state why?
Vaccine Contraindicated ☐ DNA or Absent ☐ Refused on the Day ☐
Deferred ☐ Other _____
DDMMYYYY

Notes/Comments:
