

Health PEI

Influenza Immunization Clinic Registration Form

2024/2025

Date of Clinic: _____ Location of Clinic: _____

Client Name: _____ Health Card Number: _____

DOB: _____ Age: _____ Sex: _____

Civic Address: _____ Postal Code: _____

Telephone Number: _____ Email: _____

Part 1: To be completed by Nurse: *Nurse Screening*

If client is < 9 years old, is this their first influenza vaccine? Yes No

Are you sick or do you have a fever today? Yes No

Do you have any allergies? Yes No

Have you ever had a severe/anaphylactic reaction to the influenza vaccine before? Yes No

Have you ever had Guillain-Barre Syndrome? Yes No

*If yes, was it after an influenza vaccine? Yes No

Part 2: To be completed by Parent/Guardian: *Informed Consent for Children*

I have read or have had the information sheets about the influenza immunization read to me and understand the information about the immunization my child will receive. The nature and anticipated effect of this immunization including the risks and benefits have been explained to me and I am satisfied with these explanations and I understand them. I have had the opportunity to ask questions and have them answered.

Print name (parent/guardian) _____ Date: _____

Signature: _____ Relationship to the child: _____

Part 3: To be completed by Nurse: *Vaccine Administration*

Inactivated -FLUZONE SD 0.5ml Injection site: IM Deltoid Right Left
IM Anterolateral Thigh Right Left

Inactivated-FLUZONE-HD 0.7ml Injection site: IM Deltoid Right Left

Live Attenuated FLUMIST 0.2 mL Intranasal

Lot #: _____ Manufacturer _____ Date: _____

Nurse Administering Vaccine: _____ RN LPN

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