Influenza Consent & Medical Eligibility

QIV Vaccine - Quadrivalent influenza vaccine virus (split viron, inactivated) or Influvac Tetra only

Complete this part for the person being vaccinated (PLEASE USE BLOCK CAPITALS)

Name: Date of Birth:

Please answer the following questions 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. If no, GO TO NEXT QUESTION.

2a. Has this person ever required admission to ICU for a previous severe anaphylaxis to egg? Yes ☐ No ☐

If yes, those requiring non-live influenza vaccine who have had a previous ICU admission for a severe anaphylaxis to egg need to be referred for specialist assessment with regard to vaccine administration in hospital. If yes, go to Question 2b. If no, go to Question 3.

2b. Has this person had a specialist assessment regarding their severe egg allergy in the past requiring ICU admission and are now recommended the QIV vaccine here? Yes ☐ No ☐

If yes, GO TO NEXT QUESTION. If no, they cannot be vaccinated today.

3. Is this person suffering from an acute febrile illness?

If yes, they cannot get this vaccine today, defer vaccination until recovery. If no, GO TO NEXT QUESTION.

4. Is this person on combination checkpoint inhibitors such as ipilimumab or nivolumab? Yes ☐ No ☐

If yes, they cannot have the vaccine. They should not receive any influenza vaccines, because of a potential association with immune related adverse reactions. If no, GO TO NEXT QUESTION.

5. Does this person have severe neutropenia (low levels of a type of white blood cell) i.e. absolute neutrophil count <0.5 × 10^9/L.? This does not apply to those with primary autoimmune neutropenia. Yes ☐ No ☐

If yes, they should not receive any vaccines, to avoid an acute vaccine related febrile episode. Ineligible for vaccination. If no, GO TO NEXT QUESTION.

6a. Is this the first time this person is receiving the flu vaccine this season (September to April)? Yes ☐ No ☐

If yes, go to Question 7. If no, please answer question 6b.

6b. Very few people need a second dose of flu vaccine. Does the person receiving the vaccine fit any of the following criteria: Yes ☐ No ☐

- **For children, are they between 6 months to 8 years of age and receiving influenza vaccine for the first time**
- **Post haematopoeitic stem cell transplant or post solid organ transplant**
- **Cancer patients who received the first flu vaccine while on chemotherapy in this flu season or who completed their treatment in the same flu season (September to April).**

7. Does this person have any illness or condition that increases their risk of bleeding? Yes ☐ No ☐

If yes, 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 <50x10^3), consult the supervising consultant. Proceed if fits clinical criteria.

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For people aged 16 years and older

One of these options is appropriate when establishing consent (please tick as appropriate)

1. The individual has consented to vaccination for Influenza and has been provided with written information, **OR** ☐
2. The individual does not agree with Influenza vaccination and should not be vaccinated, **OR** ☐
3. The individual cannot consent and they are being vaccinated for Influenza according to their benefit and will and preference, **AND** ☐

The above is recorded in their healthcare record and includes information about any consultation that has taken place to help determine their will and preference.

For people aged 15 years and younger

Please note only a parent or legal guardian can consent or refuse consent for people aged 15 years and younger.
I confirm that I am authorised to give consent on behalf of the above named young person.
I understand I am giving consent for the administration of a dose or for the primary course consent for the administration of two or three doses of COVID-19 at the appropriate interval.

Signature _____ Date _____ (DD/MM/YYYY)

Name (Please print) _____ (Please tick) Parent ☐ Legal Guardian ☐ Self ☐

This Young person assents to receiving the vaccine (Please tick) ☐

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Name of Vaccinator _____ Registration Number / PIN / MCRN _____

I confirm that the information collected on this form has been added to the ICT system (tick box) ☐

Name _____

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