Influenza Consent & Medical Eligibility

For Healthcare workers

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

Privacy Statement: HSE staff are aware of their obligation under the Data Protection Acts 1988 - 2018 (including GDPR). The information provided will be included in an immunisation database. The HSE will use this information to validate clients, monitor vaccination programmes and health care provision.

Complete this part with your details (PLEASE USE BLOCK CAPITALS)

First Name: Surname:

Date of Birth: Gender: (circle) Male Female

Mobile Phone:

Email address:

Staff Group: (see page 3 for a full list)

Do you work directly with patients: (circle) Yes No

Is this the first time you have had the flu vaccine? (circle) Yes No

Employer: (eg HSE CHO)

Work Location: (eg CHO9)

County: (eg Dublin)

Service: (eg Mental Health)

Service Sub Grouping: (eg Mental Health Residential)

Name of Work Location: (eg Dublin City Mental Health)

Name of Ward/Department: (eg Phoenix Care)

Please answer the following questions with a yes or no answer

1. Have you 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. Have you 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. Have you had a specialist assessment regarding your 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, you cannot be vaccinated today.

3. Are you suffering from an acute febrile illness? Yes ☐ No ☐
If yes, you cannot get this vaccine today, defer vaccination until recovery. If no, GO TO NEXT QUESTION.

Answer more questions on page 2

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Complete this part with your details (PLEASE USE BLOCK CAPITALS)

Name: Date of Birth:

Please answer the following questions with a yes or no answer

4. Are you on combination checkpoint inhibitors such as ipilimumab or nivolumab? Yes ☐ No ☐

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

5. Do you 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, you 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 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. Do you fit any of the following criteria: Yes ☐ No ☐

- **For children, are you 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. Do you have any illness or condition that increases your 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, the vaccinator will tell you about this risk. For those with thrombocytopenia (platelet count <$50x10^3$), you will need to consult the supervising consultant. Proceed if fits clinical criteria.

Consent

I consent for vaccination with influenza vaccine.

I have read and understand the accompanying vaccine information, including risks and side effects.

Signature: Date:

FOR OFFICE USE ONLY

Date Given (DD/MM/YYYY)	Vaccine Name & Manufacturer	Batch Number	Expiry Date Month/Year	Site of Vaccination	Name of Vaccinator (please print) and PIN/MCRN

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

Name

Staff Groups

Nursing: Nurses, Midwives, Nurse Manager/Person in charge, Student Nurses

Medical & Dental Professionals: Doctors, Consultants, Dentists, Orthodontists, Dental Nurses, Student Dentist, Student Doctor, Student Dental Nurse

Health & Social Care Professionals: Physical Therapist, OT, Dietician, Radiographers, Laboratories Staff, CWO, Social Workers, EMT, Audiologist, Phlebotomist, MLSO, MLA, Environmental Health Officer, Psychologist, Speech & Language Therapist, Sonographer, Psychotherapist, Podiatrist, Pharmacist, Pharmacy Technician, Physical & Sensory, Orthotist, Counsellor for special needs, Child & family development, Autism therapist, Assistive Technology, Student

Other Patient & Client Care Groups: Health care assistants, Home support workers, Attendant/aid, dental assistant, Key worker, Mortuary technician, Cardiac Technician

General Support Staff: Caretaker, Chaplin, Domestic, Driver, Engineering, Gardner, Kitchen, Maintenance, MTA, Photographer, Porter, Radio, Security, Shop, TSD

Management & Admin: Business manager, Clerical officers/Admin, General Manager, Head of Service, IT Department, Project Manager, Service manager, Co Ordinator

Other: Other