Kateri Memorial Hospital Centre
P.O. Box 10, Kahnawake, Que., J0L 1B0

Name:

Date of Birth:

Medicare #:

Check the appropriate box:

- ☐ Aged 6-23 months (Blank)
- ☐ Age 60 year + (Blank)
- ☐ Age 2-59 years with a chronic condition such as: **(P3)**
  - Blood disease
  - Cancer
  - Diabetes
  - Heart disease
  - Lung disease (i.e. Asthma, emphysema, COPD)
  - HIV
  - Immune system deficiency
  - Kidney disease
  - Metabolic anomalies
- ☐ Pregnant over 13 weeks **(P4)**
- ☐ Age 2-59 years living with or caring for one of the above at risk persons **(P5)**

Check the appropriate box:

☐ Yes ☐ No Do you have any allergies?

☐ Yes ☐ No Are you allergic to eggs?

☐ Yes ☐ No Have you had any reaction to a vaccine in the past?

☐ Yes ☐ No Have you read the information in the handout about the influenza vaccine?

☐ Yes ☐ No Do you have any questions?

I consent to have the vaccine(s). I agree to wait <u>15 minutes</u> after vaccination before leaving because any symptoms of an allergic reaction will appear within a few minutes after vaccination. I realize that the person giving the vaccine will be able to treat this reaction immediately.

_____ _____
Patient's signature or parent of child less than 14 years old Date

<u>INFLUENZA</u> **<u>Vaccine given</u>:** ***<u>****FOR NURSE ONLY****</u>***

☐ **FLUVIRAL** Lot # ☐ **AGRIFLU** Lot #

☐ **FLUMIST** Lot # ☐ **INFLUVAC (18years+)** Lot #

☐ **FLUZONE (6-24 months)** Lot #

Site: ☐ Rt Arm ☐ Lt arm ☐ Rt leg ☐ Lt leg

_____ _____
Nurse's signature Date

☐ **PNEUMOVAX- 23** Lot# _____

Site: ☐ Rt Arm ☐ Lt arm ☐ Rt leg ☐ Lt leg

_____ _____
Nurse's signature Date