Clear Form

Health PEI
One Island Health System

# Influenza Immunization Clinic Registration Form 2016/2017

Client Name:
Client's Civic Address:
Street:
Town/City:
Postal Code:

**Part 1: To be completed by Admin Support**

| | | | |
|---|---|---|---|
| ☐ | 6 - 59 months | Date: | |
| ☐ | 65 + | Clinic Location: | |
| ☐ | Pregnant | Age: | |
| ☐ | Household Contacts of Pregnant Woman | | |
| ☐ | Self Identifies as an Aboriginal person | **Fact Sheet Given:** | ☐ |
| ☐ | Resident of Community Care Facility | **Consent Given:** | ☐ (<18 yrs) |

Free:_____ Paid:($7.00) _____ Out-of-Province:($7.00) _____ Out-of-Country:($40.00) _____

**Part 2: To be completed by Nurse**: **Nurse screening**

| | | |
|---|---|---|
| If client is a child < 9 years old, is this their first influenza vaccine? | ☐ Yes | ☐ No |
| Are you sick or do you have a fever today? | ☐ Yes | ☐ No |
| Have you ever had an 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 3: To be completed by Nurse: Vaccine administration**

| | | | |
|---|---|---|---|
| ☐ Fluzone/FluLaval 0.5ml | Injection site: IM Deltoid | ☐ Right | ☐ Left |
| | Injection site: IM Anterolateral Thigh | ☐ Right | ☐ Left |
| ☐ FluMist 0.2ml | Administration: | ☐ Intra-nasal | |
| ☐ Fluad 0.5 ml | Injection Site: IM Deltoid | ☐ Right | ☐ Left |
| Lot #: _____ | Date: _____ | | |
| Nurse Administering Vaccine: | _____ Signature | ☐ RN | ☐ LPN |

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