Work Health PROFESSIONALS

Workplace Vaccination Consent Form

Name: _____ DOB: _____

Employer: _____ Site: _____

Please answer all questions carefully	**Yes**	**No**
Do you currently have a fever or infection?	☐	☐
Do you have any severe allergies (ie: yeast)?	☐	☐
If yes, please list: _____		
Have you ever had a severe reaction following a vaccine?	☐	☐
Have you ever fainted after a vaccination?	☐	☐
Do you have a chronic heart condition, lung disease, cancer or a condition affecting your immunity?	☐	☐
Are you under 18 years old?	☐	☐

Please DO NOT attend for your vaccination if you have a fever, symptoms of Covid-19 or you have had contact with anyone who has tested positive for Covid-19 in the 14 days prior to your appointment.

I consent to receive the following vaccines:

☐ Twinrix - Hepatitis A & Hepatitis B

☐ Avaxim/Havrix - Hepatitis A only

☐ Engerix B/HB Vax II - Hepatitis B only

☐ ADT booster - Tetanus and diphtheria

☐ Boostrix/Adacel- Pertussis, tetanus, diphtheria

Informed Consent

- ✓ I have understood the information provided to me about the vaccine/s
- ✓ I am aware of the possible side effects
- ✓ I have had a chance to ask questions
- ✓ I consent to receive the vaccine/s
- ✓ I understand I need to wait for 15 minutes after this vaccination

Sign: _____

Date: _____

Office use only

Vaccine	Batch no.	Given by	Dose no.	Date