

# Appendix 1

Note: In many situations use of a written consent form is not required. See page 23 for more information.

## 2026 Flu vaccination consent form

### Person

Surname \_\_\_\_\_ First name \_\_\_\_\_

Phone \_\_\_\_\_ Date of birth  $\frac{\text{DD}}{\text{MM}} / \frac{\text{MM}}{\text{MM}} / \text{YYYY}$  Age \_\_\_\_\_ years

Address \_\_\_\_\_

Medical Centre/GP \_\_\_\_\_ NHI \_\_\_\_\_  
National Health Index number if known

### Ethnicity (please tick one or more)

- NZ European  Māori  Samoan  Cook Island Māori  Tongan  Niuean  Chinese  
 Indian  Other – please state \_\_\_\_\_

### Consent statements

- I have read the fact sheet called 'Before and after Flu vaccination – fact sheet', and kept a copy or photographed so I can refer to it after I leave the appointment.
- The benefits and risks of the flu vaccine have been explained to me. I have had enough time to ask questions and my questions were answered to my satisfaction. I have been advised of the different types of flu vaccine available to me and my options.
- I have been told how long I will need to wait after the vaccination.
- I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms after the immunisation which may be vaccine related.
- I understand this vaccination will be recorded by Health New Zealand on the Aotearoa Immunisation Register (AIR) and can be accessed by authorised health care staff e.g. my GP.
- I have been provided with the AIR privacy information.
- The vaccinator has discussed with me other vaccines that I am eligible for and I do/do not (circle one) consent to receiving the following vaccine/s \_\_\_\_\_ (vaccinator to complete).
- I consent to the flu vaccination being given.

Signature \_\_\_\_\_ Date  $\frac{\text{DD}}{\text{MM}} / \frac{\text{MM}}{\text{MM}} / \text{YYYY}$

### As parent / legal guardian / enduring power of attorney

I \_\_\_\_\_ am the parent, legal guardian or enduring power of attorney, and agree to the flu vaccination of the person named above.

Relationship to person being vaccinated \_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date  $\frac{\text{DD}}{\text{MM}} / \frac{\text{MM}}{\text{MM}} / \text{YYYY}$

# Vaccination record (for vaccinator use)

Consumer details confirmed  Affirmative answer to any screening questions?  Yes  No

If yes, record the detail and advice given \_\_\_\_\_

Verbal and written post vaccination information given

Previous vaccination records checked prior to administration and other eligible vaccines offered eg Tdap / MMR / Shingles

Discussed with consumer influenza vaccines available and pros and cons of these as appropriate

Informed consent obtained?  Yes  No

<b>Influvac Tetra (Funded)</b> 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> As required
<b>Flucelvax (Unfunded)</b> 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> As required
<b>Fluzone (Unfunded)</b> 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> As required
<b>Fluad (Unfunded)</b> 50 years and over	Dose 1 <input type="checkbox"/> 50 years and over	

\* Two doses separated by at least four weeks if being administered for the first time to a child 3 years and under OR as recommended in the Immunisation Handbook

## Flu vaccination details

Name of vaccine	Batch	Expiry	Dose	Needle size	Site	Date	Time
Write vaccine name or place vaccine sticker here					Deltoid <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Funded <input type="checkbox"/> Non-funded							

## Other vaccines given (vaccinator must ensure informed consent has been obtained for these)

Vaccine details	Batch	Expiry	Dose	Needle size	Site	Date	Time
Write vaccine name or place vaccine sticker here					Deltoid <input type="checkbox"/> L <input type="checkbox"/> R		

### Vaccinator information

Place of vaccination \_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_

Signature \_\_\_\_\_

### Observation period

Details of any AEFI or observations recorded

CARM report completed

Signature \_\_\_\_\_

Departure time \_\_\_\_\_

### Clinical supervisor (if relevant)

Name \_\_\_\_\_

Signature \_\_\_\_\_

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For more information visit [info.health.nz/flu](http://info.health.nz/flu)