INJECTABLE INFLUENZA VACCINE CONSENT FORM (VERBAL)

| ast Name: | | First Na | ame: | | Date of Birth (YYYY/MM/DD): |
|--|--|--|--|---|--|
| ddress: | | | | Telephone Nun | nber: |
| Emergency Contact and Relation: | | | | Emergency Telephone Number: | |
| ana a al II a aleb Nivers a co | | T.com | | Duo an an au Chah | |
| Personal Health Number: | | Sex: ☐ Female ☐ Male ☐ Transgender | | Pregnancy Status: □ No □ Yes □ N/A | |
| OTHER HEALTH | |)N | | | |
| My immune system i | is affected by a seve | ere disease or medic | ation. If checked, please s | specify: | |
| • | | | to a vaccine/food/drug. | | |
| 1 | | | | | vaccine without another cause being |
| I have fainted during | :/after receiving a v | accine in the past. | | | |
|] I am receiving a CTLA | 4-4 inhibitor (e.g. ip | ilimumab) alone or ir | n combination with other | checkpoint inhibitor | rs for the treatment of cancer. * |
| CONSENT | ☐ Client | ☐ Parent | ☐ Legal guardia | an 🗆 Repr | esentative |
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^{*}Inactivated influenza vaccine should be given 8 weeks before starting treatment or 8 weeks after the last CTLA-4 inhibitor dose. For more specific details refer to the <u>BC Cancer Influenza vaccine recommendations</u>.