**Wargrave Surgery: Flu Form 2020**

**Under 65**

We will be running the flu clinics differently this year due to the COVID pandemic.

Please have this consent form completed and signed before you come to the surgery and bring it with you.

**Name: ………………………………………………………………………………..**

**Age: ……………………………. Dob: …………………………..........**

**Ethnicity: White British □ Asian □ Black African □ Black Caribbean □**

 **White European □ Chinese □ Other: …………………………………….**

 **We are asking for this as it may become relevant in the coming months due to the COVID 10 pandemic**

**--------------------------------------------------------------------------------------------------------------**

**Are you a carer? Y/N**

**Who do you care for? …………………………….. Relationship ………………………….**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you served in the Armed Forces? Y/N**

**Which Service? ……………………………….. Dates …………………to…………………………**

**Do you have any of the following:**

 **HEART DISEASE Y/N DIABETES Y/N**

 **RESPIRATORY PROBLEMS Y/N KIDNEY DISEASE Y/N**

 **LOWERED IMMUNITY Y/N LIVER DISEASE Y/N**

 **CARDIOVASCULAR DISEASE Y/N**

 **CARER OF SOMEONE WITH LOWERED IMMUNITY Y/N**

 **PLEASE TELL THE NURSE IF:**

**-** You are pregnant – How many weeks?

- You have had a breast operation – Do NOT have an injection in that arm

- You have had a reaction to a previous vaccination?

- You are unwell today

- You are undergoing radiotherapy or chemotherapy treatment

- You are allergic to eggs or chicken, or to (rare): Neomycin, or Polymyxin

**I CONFIRM THAT NONE OF THE ABOVE APPLIES TO ME.**

**SIGNED: …………………………………………………………**

**OFFICE USE ONLY:**

**FLU? BATCH NO:**

**DATE: ON COMPUTER:**