**Deansgrange Medical Centre**
**2 Clonkeen Road, Blackrock,**
**Co. Dublin.**

# Influenza Immunisation Consent Form

**Patient's name & DOB:** (place addressograph here)

**Lot Number:** **Expiry date:**

I have been fully informed about the above vaccine and which disease it provides protection against, the possible side effects, when they might occur and how they should be treated. I confirm by signing this form that I'm authorising consent for the administration of this vaccine to me.

**Patient's signature: _____ Date: _____**

**Administered by: _____ Date: _____**