MEDICAL IN CONFIDENCE

HEALTH EVALUATION QUESTIONNAIRE

Please read the following questionnaire. If any of the responses are YES, please inform the Occupational Health Nurse before your vaccination.

		Yes	No
1	Are you suffering from any acute illness?		
2	Are you receiving any medical treatment? (i.e. Steroids, radiotherapy, cytotoxic drugs, injections for hay fever or other allergic conditions)		
3	Are you suffering from any severe medical condition?		
4	Have you received any vaccinations in the last 3 weeks?		
5	Are you allergic to eggs?		
6	Are you allergic to any drugs? (e.g. Antibiotics)		
7	Do you suffer from any skin conditions?		
8	Is your 65th birthday on or before 31st March 2025		
9	Have you ever reacted to a vaccine in the past?		

Print Name: Date:

…… ……/……/……...

Signed:

……

OHA Review

Vaccination Given Yes ☐ No ☐

Date:

……..

Injection site:

……...

Signed:

……..

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