Influenza Vaccination Patient Screening and Consent

Patient Name: _____ Date of Birth: _____ Age: _____

Gender: _____ Weight: _____ Health Card #: _____

Address: _____ Tel: _____

Emergency Contact Name: _____ Tel: _____

Physician/Nurse Practitioner Name: _____ Physician/NP Tel: _____

As of today, COVID-19 Screening:	**Yes**	**No**
Do you feel unwell today, have a fever or a cough (new or worsening), shortness of breath, or difficulty breathing?		
Do you have any of the following symptoms: runny nose/nasal congestion, sore throat, difficulty swallowing, chills, headache, new onset fatigue, new onset muscle pain, nausea/vomiting, diarrhea, pink eye, loss of taste or smell?		
Ontario only: >70y.o. with delirium, unexplained or increased number of falls, worsening chronic conditions?		
Have you travelled outside of Canada/Atlantic Canada within the last 14 days?		
Have you been in contact with someone that has tested positive for COVID 19 in the past 14 days?		
☐ REFERRED TO 811 (Atlantic) / TELEHEALTH (Ontario); PATIENT DID NOT RECEIVE IMMUNIZATION		

As of today, Pre-Immunization Assessment:	**Yes**	**No**
Is this the first time you are receiving an influenza vaccine?		
Have you ever fainted or had a serious reaction (including anaphylaxis) to any previous injection or vaccine(s)? If yes, please describe the reaction:		
Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving an influenza vaccine?		
Do you have an allergy to any of the following? Please check all that apply: ☐ Latex ☐ Thimerosal ☐ Formaldehyde ☐ Triton®X100 ☐ Neomycin ☐ Kanamycin ☐ Gentamycin ☐ Polysorbate 80 ☐CTAB (Cetyltrimethylammonium Bromide) ☐ Sodium Deoxycholate ☐ Sucrose		
Do you have an egg allergy? (For monitoring purposes)		
Do you have any allergies to any medications? If yes, please list:		
Do you have any chronic health conditions **OR** conditions which may lower your immunity? (e.g.: asthma, diabetes, HIV, cancer, bleeding disorders) If yes, please list:		
Are you currently on any medications (prescriptions, non-prescription, herbal products etc.) **OR** are you taking any treatment that lowers immunity (prednisone, radiotherapy, chemotherapy) **OR** taking any blood thinners? If yes, please list:		
Are you pregnant?		

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- My pharmacist has reviewed with me the benefits, side effects, risks (including risks of not receiving vaccine) associated with the influenza vaccine being administered today.
- I have had the opportunity to have my questions answered.
- I/my dependent, agree to remain at the pharmacy for at least 15-30 minutes following administration of the medications/ vaccine or as directed by the pharmacist. (Egg allergy requires 30 minutes.)
- I authorize my pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction and to notify my emergency contact person.
- I authorize my pharmacist to notify my physician/nurse practitioner and/or public health of the vaccine received and to contact me with any follow-up if needed.

☐ **I consent to receive the influenza vaccine today**

☐ **I consent for my child/dependent to receive the influenza vaccine today**

Name (print): _____ Signature: _____
(Guardian/ agent as required)

Date: _____

PHARMACIST DOCUMENTATION

☐ **Fluzone MDV DIN 02432730** ☐ **Fluzone PFS DIN 02420643** ☐ **FluLaval Tetra DIN 02420783** ☐ **Fluzone High-Dose DIN 02445646** ☐ **Flucelvax Quad DIN 02494248** ☐ **Other:** _____	**Dose:** _____	Lot: _____	Exp (mm/dd/yy): _____

Route: ☐ IM ☐ Intranasal **Injection Site:** Deltoid ☐ Left ☐Right

Date (mm/dd/yy): _____ **Time:** _____ AM / PM

Patient monitoring and follow up:

15-30 minutes post injection: ☐ Patient appears fine, no adverse reaction(s)

Comments:

Pharmacy Name: _____ **Tel:** _____

Pharmacist / Pharmacy Technician Name: _____

Lic #: _____ **Signature:** _____

Communication to other Health Care Providers (physician, nurse practitioner, public health) via
☐ **Fax** ☐ **DIS**

Print Form **Save Form**