VACCINE ADMINISTRATION SCREENING & CONSENT FORM

Please complete this form and read the information provided before receiving _____ (name of vaccine). Your answers to these questions will help the Pharmacist determine if there are any reasons why you should not receive this vaccine at this time. If you are a parent or guardian providing consent for a child or other person, please complete this information for the person who will be receiving the vaccine.

Patient Information

First Name: Last Name:

Date of Birth: (dd/mm/yyyy): Age: Sex: ☐ M ☐ F ☐ Other

Address:

Street Apt. City Province Postal Code

Health Card Number: Telephone Number:

Emergency Contact Name & Telephone Number:

Screening Questionnaire for Person Receiving Vaccine

Are you sick today (eg, fever over 39.5°C, breathing problems, active infection)?	☐ Yes	☐ No
Do you have any allergy to medication, vaccine, latex, or food?	☐ Yes	☐ No
Do you take any blood thinners (eg, ASA/Aspirin, etc.) or have a bleeding disorder?	☐ Yes	☐ No
Have you had a serious reaction to a medication or vaccine in the past?	☐ Yes	☐ No
Do you have a new or changing condition affecting the brain or nervous system?	☐ Yes	☐ No
Have you ever had Guillain-Barré syndrome?	☐ Yes	☐ No
For Live Vaccines Only:		
Are you pregnant, planning to become pregnant, or breastfeeding?	☐ Yes	☐ No
Do you have a long-term medical condition such as asthma, diabetes, lung disease, heart disease, or kidney disease?	☐ Yes	☐ No
Have you received a blood transfusion, blood product, immune globulin, or antiviral drug in the past year?	☐ Yes	☐ No
Do you have a medical condition or are you taking medication that affects your immune system (eg, cancer, HIV, taking prednisone or other corticosteroids)?	☐ Yes	☐ No
Have you received any vaccines in the past 4 weeks?	☐ Yes	☐ No
Are you under 18 years of age and taking medication containing ASA/Aspirin?	☐ Yes	☐ No

Patient/Agent Consent for Vaccine Administration

I consent to having The Healing Source Pharmacy Pharmacist administer _____ (name of vaccine). I have reviewed the information about this vaccine and procedure provided to me, and the pharmacist has answered any questions I may have or have had. I understand the risks, benefits, expected outcome(s), and possible side effects of this vaccination and agree to wait in the pharmacy for 15 to 30 minutes after receiving the vaccine. I agree to see a doctor if I develop any side effects or health problems after receiving the vaccine. I agree that The Healing Source Pharmacy may share my personal health information regarding this vaccination with public health officials and/or other healthcare providers as required.

☐ I am providing consent for myself

☐ I am providing consent for the patient identified above

If providing consent for the patient identified above, please complete the following:

Contact information of patient's agent (name and telephone): _____

Relationship: ☐ *Parent* ☐ *Guardian* ☐ *Other (please specify)* _____

Name of person providing consent (if other than patient): _____

Signature of patient or person providing consent: _____ Date: _____ / _____ / _____

dd mm yyyy

Pharmacy Use Only – Pharmacist Documentation

Vaccine product administered: ☐ Engerix-B ☐ Engerix-B Pediatric ☐ Gardasil-9 ☐ Havrix 1440 ☐ Havrix 720 Junior ☐ Prevnar-13 ☐ Prevnar-20 ☐ Recombivax HB ☐ Recombivax HB Pediatric ☐ Shingrix ☐ Twinrix ☐ Twinrix Junior ☐ Other: _____	☐ 1st dose _____ ☐ 2nd dose _____ ☐ 3rd dose _____ ☐ Other: _____ Lot Number: Expiry Date:
Date of administration (dd/mm/yyyy):	Time of administration: _____ AM / PM

Route and site of administration: ☐ IM ☐ SC Deltoid: ☐ Right ☐ Left ☐ Other: _____

Rationale for vaccination administered	☐ Prevention of disease: _____ ☐ Demonstration: _____ ☐ Other comments:
Patient counselling	☐ Potential adverse reactions and their management ☐ Other comments:
Patient response	Adverse reaction? ☐ Yes ☐ No (if yes, describe nature of the reaction and action(s) taken) after 15 minutes? _____
Follow-up	☐ Yes ☐ No ☐ Next dose due: _____ Details: _____
Communication	☐ Public Health ☐ Healthcare Provider Name: _____ Method of notification: ☐ Fax ☐ Phone ☐ Other: _____ Date notified: _____ Details: _____

I confirm that the patient named in this document is capable of providing consent to receive the vaccine indicated or that a parent, guardian, or other agent has provided consent on behalf of the patient. I confirm that this vaccine should be given to the patient based on my assessment.

Name of Pharmacist Administering Vaccine: _____

Pharmacist Licence Number: _____ Signature: _____