SEASONAL INFLUENZA VACCINE SCREENING AND CONSENT FORM

Please complete this form and read the supplemental information provided before receiving your Influenza Vaccine (“Flu Shot”). Your answers to these questions will help the Pharmacist determine if there is any reason why you should not receive the flu shot 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:
Address: Street / Apt. / City / Province / Postal Code		
Health Card #:	Telephone Number:	
Emergency Contact Name and Telephone Number:		

Screening Questionnaire for Person Receiving Vaccine

Screening Questionnaire for Person Receiving Vaccine	Yes	No
Are you sick today (eg, fever over 39.5°C, breathing problems, active infection)?		
Do you have any allergy to medication, vaccine, latex, or food?		
Have you ever had a severe reaction to eggs or egg products?		
Do you take a blood thinner (eg, Aspirin, etc.) or have a bleeding disorder?		
Have you ever fainted or had a serious reaction to a medication or vaccine in the past?		
Do you have a new or changing condition affecting the brain or nervous system?		
Have you ever had Guillain-Barré syndrome?		
Are you pregnant, planning to become pregnant, or breastfeeding?		
Optional:		
For individuals **over 50 years old**, have you received a **pneumonia** vaccine?		
For individuals **over 50 years old**, have you received **shingles** vaccines?		
For individuals **over 60 years old**, have you received an **RSV** vaccine?		
Are your **COVID-19** vaccines up to date? (Less than 6 months from the previous COVID-19 vaccine dose or known infection)		

Patient/Agent Consent for Vaccine Administration

I consent to having The Healing Source Pharmacy Pharmacist administer the Influenza Vaccine. I have reviewed the information about this vaccine and procedure provided to me and the pharmacist has answered my questions. I understand the risks, benefits, expected outcome, and possible side effects of this vaccine 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 medication as required with public health officials and other healthcare providers.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called “anaphylaxis” can be life-threatening and are deemed medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 911 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐ 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 to person receiving the vaccine: ☐ *Parent* ☐ *Guardian* ☐ *Other (please specify)* ____________________

Name of person providing consent: ________________________________

Signature of person providing consent: ________________________________ Date: _______ / _______ / _________
dd mm yyyy

Pharmacy Use Only – Pharmacist Documentation

<table>
<tr>
<td colspan="2">

QIV Vaccine Administered:

☐ **FLUZONE Quadrivalent** (0.5mL) (2+ years)
☐ DIN: 02420643 Pre-filled Syringe
☐ DIN: 02432730 Multi-dose vial
☐ **FLULAVAL Tetra** (0.5mL) (2+ years)
☐ DIN: 02420783 Multi-dose vial
☐ **FLUCELVAX Quad** (0.5mL) (2+ years)
☐ DIN: 02494248 Pre-filled syringe
☐ **OTHER**
☐ DIN:

</td>
<td>

TIV-adj or QIV-High Dose Vaccine Administered:

☐ **FLUZONE High-Dose Quadrivalent** (0.7mL) (65+ years)
☐ DIN: 02500523 Pre-filled Syringe
☐ **FLUAD TIV-adjuvanted** (0.5mL) (65+ years)
☐ DIN: 02362384 Pre-filled Syringe

Lot Number:

Expiry Date:

</td>
</tr>
<tr>
<td colspan="2">Date of immunization (dd/mm/yyyy):</td>
<td>Time of immunization: AM / PM</td>
</tr>
<tr>
<td colspan="3">Route and site of immunization: ☐ IM Deltoid: ☐ Right ☐ Left ☐ Other</td>
</tr>
<tr>
<td>Patient counselling</td>
<td colspan="2">☐ Potential adverse reactions and their management
☐ Other comments:</td>
</tr>
<tr>
<td>Patient response</td>
<td colspan="2">Adverse reaction ☐ Yes ☐ No
(if yes, describe, nature of the reaction and action(s) taken) after 15 minutes?
______________________________</td>
</tr>
<tr>
<td>Follow-up
☐ Yes ☐ No
Details: ______________________</td>
<td colspan="2"></td>
</tr>
</table>

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

Affix label here

Name and Title of Pharmacist Administering Vaccine: ______________________________

Pharmacist Licence Number: ______________________ Signature: ______________________________