MEDICATION ADMINISTRATION SCREENING AND CONSENT FORM

Please complete this form and read the supplemental information provided before receiving _____ (name of medication). Your answers to these questions will help the Pharmacist determine if there is any reason why you should not receive this medication 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 medication.

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 Medication	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?		
Do you take a blood thinner (eg, Aspirin, etc.) or have a bleeding disorder?		
Have you 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?		
For Live Vaccines Only:		
Do you have a long-term medical condition such as asthma, diabetes, lung disease, heart disease, or kidney disease?		
Have you received a blood transfusion, blood product, immune globulin, or antiviral drug in the past year?		
Do you have a medical condition or are you taking medication that affects your immune system (eg, cancer, HIV, taking prednisone or other corticosteroids)?		
Have you received any vaccines in the past 4 weeks?		
Are you under 18 years of age and taking medication containing ASA/Aspirin?		

Patient/Agent Consent for Medication Administration

I consent to having The Healing Source Pharmacy Pharmacist administer _____ (name of medication), _____ (dose and route of medication). I have reviewed the information about this medication 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 medication and agree to wait in the pharmacy for 15 to 30 minutes after receiving the medication. I agree to see a doctor if I develop any side effects or health problems after receiving the medication. 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 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 medication:

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

Name of person providing consent: _____

Signature of person providing consent: _____ Date: _____ / _____ / _____
dd mm yyyy

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Product/medication administered: ☐ **Vaccine:** ☐ Abrysvo ☐ Arexvy ☐ Engerix-B ☐ Engerix-B Pediatric ☐ Gardasil-9 ☐ Havrix 1440 ☐ Havrix 720 Junior ☐ 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 ☐ Right ☐ Left ☐ Deltoid ☐ Other: _____	
Rationale for medication administered	☐ Prevention of disease; specify _____ ☐ Demonstration; specify _____ 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 (if yes, describe the reason for follow-up and timing) _____
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 medication indicated in this document or that a parent/guardian or other agent has provided consent on behalf of the patient. I confirm that this medication can/should be given to the patient based on my assessment.

Name and Title of Pharmacist Administering Medication: _____

Pharmacist Licence Number: _____ Signature: _____