Seasonal Influenza (Flu) Vaccine Screening and Consent Form 2025-2026

wholehealth pharmacy partners

Section 1: Patient Information

Name (First & Last):	Health Card Number:	
Preferred Name:	Date of Birth:	Weight (if under 18 years old):
Gender Identity:	Gender Associated with your Health Card (for billing purposes): ☐ M ☐ F ☐ X	
Address:	Telephone:	
	Emergency Contact (Name, Phone Number, Relationship):	

Section 2: Influenza Screening Questionnaire

Question	Yes	No	Unsure	Question	Yes	No	Unsure
Are you **sick today**? (fever > 39.5°C, breathing problems, active infection, or any symptoms of COVID-19)	☐	☐	☐	Are you **allergic** to any medications including vaccines?	☐	☐	☐
Are you **allergic** to any of the following? Latex, thimerosal, formaldehyde, TrintonX100, neomycin, kanamycin, gentamycin, polysorbate 80, CTAB (Cetyltrimethylammonium bromide), sodium deoxycholate, sucrose, arginine hydrochloride, gelatin hydrolysate	☐	☐	☐	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 had a severe reaction to **eggs** or **egg products**?	☐	☐	☐
Are you or do you think you might be **pregnant**?	☐	☐	☐	Do you have a **new** or **changing** neurological disorder?	☐	☐	☐
Have you had **Guillain Barré Syndrome** within 6 weeks of getting a flu shot?	☐	☐	☐	Do you have **bleeding a bleeding condition** or use **blood thinners**? (e.g. warfarin, aspirin)	☐	☐	☐

Section 3: Immunization Screening Questionnaire (Optional)

Question	Yes	No	Unsure	Question	Yes	No	Unsure
For individuals **over 50 years old,** have you received a **pneumonia** vaccine?	☐	☐	☐	For individuals **10-25 years old**, have you received a **meningitis B** vaccine?	☐	☐	☐
For individuals **over 50 years old,** have you received **shingles** vaccines?	☐	☐	☐	For individuals **9-45 years old**, have you received an **HPV** vaccine (Gardasil 9) before?	☐	☐	☐
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 SARS-CoV-2 infection).	☐	☐	☐

Section 4: Patient Information

I, the client, parent or guardian, have read or had explained to me information about the flu shot. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the flu shot. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu vaccine.

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 confirm that I want to receive the seasonal influenza vaccine** *OR*

☐ **I confirm that I want <u>my child</u> 2 years of age or older to receive the seasonal influenza vaccine**

Patient/Agent Name (& Relationship):	Patient/Agent Signature:	Date Signed:

Section 5: Pharmacy Use Only

Vaccine Lot:	**TIV Vaccine administered:**	**TIV-adj or QIV-High Dose vaccine administered:**
Expiry (MM/YYYY):	**FLUZONE** (0.5 mL) (*6mo+*) ☐ DIN: 02420643 PFS ☐ DIN: 02365936 Multi-dose vial **FLUVIRAL** (0.5 mL) (*6mo+*) ☐ DIN: 02420686 Multi-dose vial **FLUCELVAX** (0.5 mL) (*6mo+*) ☐ DIN: 02494248 Pre-filled syringe **FLUMIST LIVE (Covered in NB & BC only)** (0.2mL IN) (2-59 years) ☐ DIN: 02352621 Intranasal **OTHER:** ☐ DIN:	**FLUZONE High-Dose** (0.5mL) (*65+ years*) ☐ DIN: 02445646 Pre-filled syringe **FLUAD** (0.5mL) (*65+ years*) ☐ DIN: 02362384 Pre-filled syringe **OTHER:** ☐ DIN:
Date of Immunization:		
Time of Immunization:		
☐ Left arm *OR* ☐ Right arm		

PHARMACIST DECLARATION:
I confirm the above-named patient is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient.

Pharmacist:	License #:	Signature:	Date Signed:

Section 6: Epinephrine Emergency Use Only (Recommended Dose= 0.01mg/kg; MAX 0.5mg per dose)*

Patient's Last Name:	Patient's First Name:	Patient's Date of Birth (MM/DD/YYYY)
Epinephrine 0.15 mg* Children (age 2-7): Weight: 11 to 20 kg (24 - 45 lbs) ☐ **EpiPen Junior** DIN 00578657 ☐ **Allerject** DIN 002382059 **Note: Weight is the preferred basis for dosage; use age if weight is unknown**	**Epinephrine 0.3 mg*** Children (age 7-12): Weight: 21 to 45 kg (46 – 100 lbs) ☐ **EpiPen Adult** DIN 00509558 ☐ **Allerject** DIN 002382067 ☐ **Emerade** DIN 002458446	**Epinephrine 0.5 mg*** Adolescents (age 12+) and adults: Weight ≥ 46 kg (≥ 101 lbs) ☐ **Emerade** DIN 002458454

Date of Administration (MM/DD/YYYY)	Times of Epinephrine Administration 1. 2. (if needed) 3. (if needed)
Number of Doses Administered:	
Pharmacist's Name and License #:	Pharmacist Signature:
Additional Notes (any emergency measures taken, or treatments administered):	Follow-up Date (MM/DD/YYYY): Follow-up Time:

*Recommended doses from Canadian Immunization Guide https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-2-vaccine-safety/page-4-early-vaccine-reactions-including-anaphylaxis.html#t4