Consent for Administration of Influenza Vaccine

To be completed just prior to your Flu Shot Appointment

Patient Name: _____ **Sex at birth:** ○ **Male or** ○ **Female (circle)**
Date of Birth: _____ **Postal Code:** _____
Personal Health Number (PHN): _____

Please screen the patient with the following questions:	YES	NO	Comment:
1. Have you been vaccinated against influenza before?	☐	☐	
2. Have you received any vaccinations in the last 30 days?	☐	☐	
3. Are you sick today? (fever, cold, infection)	☐	☐	
4. Do you have any allergies (i.e. latex, egg, gelatin, antibiotics)?	☐	☐	
5. Do you take any medications? (prescription or OTC)	☐	☐	
6. Do you have any medical conditions?	☐	☐	
7. Do you have any respiratory conditions such as ASTHMA? (If yes, what medication or treatment have you had in the last 7 days?)	☐	☐	
8. Do you have any conditions (e.g. cancer) or take medications which may affect your immune system?	☐	☐	
9. Do you have any neurological disorders?	☐	☐	
10. Do you have a bleeding disorder or take blood thinners?	☐	☐	
11. Have you received a blood transfusion or any blood products within the last year?	☐	☐	
12. Have you ever had a serious reaction to a vaccine? Allergic reaction? Fainting? Guillain–Barré syndrome (GBS)?	☐	☐	
13. Female patients:	**YES**	**NO**	**Comment:**
a. Are you pregnant? Planning to get pregnant within next month?	☐	☐	
b. Are you breastfeeding?	☐	☐	
14. Those under 9 years of age who have never received a prior influenza vaccine require two doses (min. 4 weeks between doses)	**YES**	**NO**	
Does this pertain to this patient?	☐	☐	

Covid Assessment:	YES	NO	Comment:
15. Are you experiencing any of the following?: • severe difficulty breathing (e.g., struggling for each breath, speaking in single words) • severe chest pain • having a very hard time waking up • feeling confused • lost consciousness	☐	☐	
16. Are you experiencing any of the following?: • shortness of breath at rest • inability to lie down because of difficulty breathing • chronic health conditions that you are having difficulty managing because of your current respiratory illness	☐	☐	
17. In the past 10 days, have you experienced any of the following?: • fever • new onset of cough or worsening of chronic cough • new or worsening shortness of breath • new or worsening difficulty breathing • sore throat • runny nose	☐	☐	

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18. Do you have any of the following?: • chills • painful swallowing • stuffy nose • headache • muscle or joint ache • feeling unwell, fatigue or severe exhaustion • nausea, vomiting, diarrhea or unexplained loss of appetite • loss of sense of smell or taste • conjunctivitis (pink eye)	☐	☐	
19. In the past 14 days, did you return from travel outside of Canada, or did you have close contact with someone who is confirmed as having COVID-19?	☐	☐	

Emergency Contact Name: _____ Phone: _____

---------- FOR PHARMACY USE ONLY ----------

The pharmacist has provided the patient/guardian information around both the drug being administered and the injection procedure so that they patient/guardian understands the expected outcome/reaction as well as possible side effects.

- ☐ The patient/guardian understands that they may, at any time before, during, or after the injection, ask the pharmacist further questions.
- ☐ The patient/guardian understands that on _____(date), _____(the pharmacist) will be administering _____(drug & dose) via intramuscular injection.
- ☐ The patient/guardian understands and agrees to remain at the location for 15-30 minutes after injection as directed by the pharmacist.
- ☐ In the event of an emergency, the patient/guardian authorizes the pharmacist to administer epinephrine and/or apply necessary life-saving procedures as an interim measure until medical support personnel arrive.
  In the case of an emergency, the pharmacist should contact_____ at_____ _____(phone).
- ☐ The patient/guardian understands that they may experience symptoms following influenza immunization (e.g. fever, cough, etc.) that are similar to symptoms that present with COVID-19 infection. The patient/guardian is aware to contact HealthLink at 811 if symptoms occur.
- ☐ The patient/guardian has been provided with the above and provides verbal consent to receive the vaccination.

Signature_____(Pharmacist)

☐ **SENIOR (65 YRS/ OLDER)**	☐ **HEALTHCARE WORKER**	☐ **PREGNANT WOMAN**	☐ **ROUTINE FLU-SHOT (9-64 YRS)**

Vaccine	Lot# of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection (CIRCLE PLEASE)	Time
					IM L / R Deltoid	

_____(name) had _____(drug) _____ (dose) administered on_____(date) at_____(time).
Lot Number: _____
Arm: Left or Right (circle) Dose: 1/2 or 2/2 or N/A (circle)
Pharmacy information/stamp: **Pharmacist signature:**

24/08/20

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