PHARMASAVE

Influenza Vaccination Patient Screening and Consent

Patient Name: _____ Date of Birth: _____ Age: _____

Gender: _____ Weight: _____ Health Card #: _____

Address: _____ Tel: _____

Emergency Contact Name: _____ Tel: _____

Physician/Nurse Practitioner Name: _____

As of today,COVID-19 Screening:	**Yes**	**No**
Do you feel unwell today; have a fever (above 39.5°C) or a cough (new or worsening), shortness of breath, or difficulty breathing?	☐	☐
Do you have any of the following symptoms: runny nose/nasal congestion, sore throat, difficulty swallowing, chills, headache, new onset fatigue, new onset muscle pain, nausea/vomiting, diarrhea, pink eye, loss of taste or smell?	☐	☐
Are you >70 years old with delirium, unexplained or increased number of falls, worsening chronic conditions?	☐	☐
Have you travelled outside of the Canada within the last 14 days?	☐	☐
Have you been in contact with someone that has tested positive for COVID 19 in the past 14 days?	☐	☐
Have you ever been notified by COVID Alert that you were in the vicinity of a COVID-19 positive individual?	☐	☐
Have you received your 2nd dose of COVID-19 vaccine more than 14 days ago?	☐	☐
☐ REFERRED TO TELEHEALTH; PATIENT DID NOT RECEIVE IMMUNIZATION		
As of today, Pre-Immunization Assessment:	**Yes**	**No**
Is this the first time you are receiving an influenza vaccine?	☐	☐
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 ever developed Guillain-Barre Syndrome within 6 weeks of receiving an influenza vaccine?	☐	☐
Do you have an allergy to any of the following? Please check all that apply: ☐ Latex ☐ Thimerosal ☐ Formaldehyde ☐ Triton®X100 ☐ Neomycin ☐ Kanamycin ☐ Gentamycin ☐ Polysorbate 80 ☐ CTAB (Cetyltrimethylammonium Bromide) ☐ Sodium Deoxycholate ☐ Sucrose	☐	☐
Do you have an egg allergy? (For monitoring purposes)	☐	☐
Do you have any allergies to any medications? If yes, please list:	☐	☐
Do you have any chronic health conditions **OR** conditions which may lower your immunity? (e.g.: asthma, diabetes, HIV, cancer, bleeding disorders) If yes, please list:	☐	☐
Are you currently on any medications (prescriptions, non-prescription, herbal products etc.) and/or taking any treatment that lowers immunity (prednisone, radiotherapy, chemotherapy)? If yes, please list:	☐	☐
Do you have a bleeding condition or use any blood thinners (ex. Warfarin, low or high dose aspirin)?	☐	☐
Are you pregnant?	☐	☐

- My pharmacist has reviewed with me the benefits, side effects, risks (including risks of not receiving vaccine)

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associated with the influenza vaccine being administered today.

- I have had the opportunity to have my questions answered.
- I /my dependent, agree to remain at the pharmacy for atleast 15-30 minutes following administration of the medications/ vaccine or as directed by the pharmacist. (Egg allergy requires 30 minutes.)
- I authorize my pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction and to notify my emergency contact person.
- I authorize my pharmacist to notify my physician/nurse practitioner and/or public health of the vaccine received and to contact me with any follow-up if needed.

☐ **I consent to receive the influenza vaccine today**

☐ **I consent for my child/dependent to receive the influenza vaccine today**

Name (print): _____ Signature: _____
(Guardian / agent as required)

Date: _____

INJECTION ADMINISTRATION DOCUMENTATION:

☐**Fluzone MDV DIN 02432730**	☐**Flucelvax Quad DIN 02494248**
☐**Fluzone PFS DIN 02420643**	☐**Afluria MDV 2473313**
☐**FluLaval Tetra DIN 02420783**	☐**Afluria Tetra DIN 02473283**
☐**Fluzone High-Dose DIN 02500523**	☐**FluMist DIN 2426544**
	☐**Fluad DIN 02362384**
	☐**Other:** _____

Dose:	**Lot:**	**Exp (mm/dd/yy):**

Route: ☐ IM ☐ Intranasal **Injection Site:** Deltoid ☐Left ☐Right

Date (mm/dd/yy)**:** _____ **Time:** _____ AM / PM

PATIENT MONITORING AND FOLLOW UP:

15-30 minutes post injection:

☐Patient appears fine, no adverse reaction(s)

Comments:

Pharmacy Name: Fairway Lackner Pharmacy **Tel:** (519) 954-8794

Pharmacist : Gurinder Brar (211868) / Gurdeep Chakkal (621565)

Signature:_____