# 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: _____ Physician/NP Tel: _____

| **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 >70years 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:<br>☐ Latex ☐ Thimerosal ☐ Formaldehyde ☐ Triton®X100 ☐ Neomycin ☐ Kanamycin<br>☐ Gentamycin ☐ Polysorbate 80 ☐CTAB (Cetyltrimethylammonium Bromide)<br>☐ 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 taking any treatment that lowers immunity (prednisone, radiotherapy, chemotherapy)?<br>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? | | |

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- My pharmacist has reviewed with me the benefits, side effects, risks (including risks of not receiving vaccine) 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 at least 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** | ☐ **FluMist DIN 2426544** |
| ☐ **Fluzone High-Dose DIN 02445646** | ☐ **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:** _____ **Tel:** _____

**Pharmacist / Pharmacy Technician Name:** _____

**Lic #:** _____ **Signature:** _____

**Communication to other Health Care Providers (physician, nurse practitioner, public health) via**
**☐ Fax ☐ DIS**