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: ☐ 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 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?		

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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