INACTIVATED INFLUENZA VACCINE: PATIENT CARE AND CONSENT RECORD FOR INJECTION

Last Name of Patient | First | Middle | DOB: (DD/MM/YYYY) | Age

Permanent Address | City | Province | Postal Code | Personal Provincial Health Card #

( ) Home Phone | ( ) Cell Phone | Gender | Weight (1 kg = 2.2 lb)

Family Doctor | Emergency Contact | ( ) Emergency Contact Phone Number

Have you obtained prescriptions for yourself from this pharmacy before? ☐ Yes ☐ No

Please answer these questions by checking the boxes. These questions help us determine if there is any reason we should not give you the vaccine today. Answering "yes" to any question does not necessarily mean you should not be vaccinated – we will ask you for more information. If the question is not clear, please ask the pharmacist.		**Yes**	**No**	**Unsure**
1.	Have you had the flu vaccine before? If Yes, please list year you last received a flu vaccine:_____	☐	☐	☐
2.	Are you **sick today** (including any symptoms of COVID such as fever, chills, cough, sore throat, etc)?	☐	☐	☐
2.	Do you have an **allergy** to latex, or ANY food, medications or vaccine components? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Kanamycin). If Yes, please list: _____	☐	☐	☐
4.	Have you ever had a **serious reaction or fainted after receiving any injection**?	☐	☐	☐
5.	Have you had lymph nodes removed from your arms or chest or had a mastectomy? If so, ☐ Right ☐ Left ☐ Both (referral to physician may be necessary)	☐	☐	☐
6.	Do you take blood thinning medications or have a bleeding disorder?	☐	☐	☐
7.	Have you ever had Guillain-Barré syndrome?	☐	☐	☐

CONSENT GIVEN BY PATIENT

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the Fact Sheet. I have had a 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 shot.

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 is a medical emergency. 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 9-1-1 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.

☐ I confirm that I want to receive the seasonal influenza vaccine.

☐ Patient Signature: _____

☐ Parent/Guardian or authorized decisionmaker – (include printed name)_____ Signature:_____

Date: _____

---------- BELOW LINE FOR PHARMACY USE ONLY- ADD NOTES ON REVERSE AS NEEDED ----------

Check Box to Confirm Patient Identity Verified ☐ **Check box to Confirm Vaccine/Drug to be administered Verified** ☐

Drug & DIN	Lot#	Exp Date	Manufacturer	Dosage	Site of Injection	Sequence	Time
					IM L / R Deltoid		

Written info and verbal counseling provided to patient ☐

Additional Assessment Notes (if applicable) : _____

Monitoring Post-Injection: ☐ Well Tolerated Reaction? : ☐ No ☐ Yes_____

Signature of Immunizer : _____ **License/Permit #**_____ **Date:** _____