Consent for Administration of Influenza Vaccine

Patient Name: _____ **Phone Number:** _____
Personal Health Number (PHN): _____ **Date of Birth:** _____
Address & Postal Code: _____ **Age:** _____
Gender: _____ **Weight:** _____
Emergency Contact Name: _____ **Emergency Contact Number:** _____

Please screen the patient with the following questions:	YES	NO	Unsure
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, chills, cough etc.)	☐	☐	☐
4. Do you have an allergy to latex, or ANY food, medications or vaccine components? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin, Kanamycin).	☐	☐	☐
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 or fainted after receiving any injection? Allergic reaction? Fainting? Guillain–Barré syndrome (GBS)?	☐	☐	☐
13. 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)	☐	☐	☐
13. Female patients:	**YES**	**NO**	**Unsure**
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	☐	☐	
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)	☐	☐	☐

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19. Did you recently receive a positive test result on a COVID-19 Point of Care (POC) test, taken somewhere other than an AHS assessment center, that requires confirmation?	☐	☐	
20. In the past 14 days, were you notified that you were connected to an outbreak by: • AHS • Your employer • The organizer of a social or sporting event you attended	☐	☐	
21. 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?	☐	☐	

Consent:

I confirm that I have been provided with written information, a copy of which is included with this Consent and Release, about the vaccine being administered, the vaccine injection procedure, and information regarding the risks, benefits, expected outcome/reaction and the possible side-effects of the influenza vaccine I acknowledge that I have reviewed those materials in advance of receiving the vaccination and that I understand the benefits and risks, the expected outcome/reaction as well as the possible side effects of the requested vaccination. I understand and agree to remain at this location for 15-30 minutes after the injection as directed by the pharmacist. I confirm that North Central COOP Pharmacy has answered to my satisfaction all my questions about the vaccine and the vaccine injection procedure. I understand that I may ask the pharmacist further questions at any time before, during, or after the vaccine injection.

I understand that, by providing the information on this form, I am giving North Central COOP Pharmacy permission to collect, use, and release any medical or other information necessary to my physician, provincial health care, or insurance company or immunization registry, as applicable, to process my insurance claims with respect to the vaccination. The collection, use, and disclosure of the information provided on this form is protected by applicable provincial privacy legislation.

In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary lifesaving procedures as an interim measure until medical support personnel arrive. In case of emergency, I understand that on the date indicated below, the pharmacist will be administering the vaccine named below at the dose indicated. I understand that the pharmacist: (i) has been trained and is registered to administer injections by the Provincial College of Pharmacy; (ii) is aware of and agrees to comply with all professional standards surrounding administering of injections as well as general pharmacy practice; (iii) maintains current certification in cardiopulmonary resuscitation (CPR) and basic first aid.

Please contact the person I have named above as an Emergency Contact.

I, for myself (or for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby ACKNOWLEDGE AND AGREE THAT I AM VOLUNTARILY PARTICIPATING IN THIS ACTIVITY WITH THE KNOWLEDGE OF THE RISKS INVOLVED AND ASSUME ALL RISKS ASSOCIATED WITH THE ADMINISTRATION AND THE VACCINE.

I have read and understand the above information. I request and consent that the vaccine be given, as I direct North Central COOP Pharmacy, either to me or to the person named above, a minor for whom I have legal authority to represent that I am authorized to sign this Consent and Release. I confirm that I have the legal authority to consent to this immunization.

Printed name of person giving consent	Relationship	Other phone
Signature of person giving consent		Date

----------BELOW LINE FOR PHARMACY USE ONLY----------

☐ Patient Identity Verified ☐ Confirm Vaccine/Drug to be administered ☐ Verified Drug & DIN

Vaccine Administered ☐ Fluzone QIV ☐ Fluzone HD QIV

Lot# _____ Exp Date: _____

Dosage _____ Site of Injection IM ☐ L Deltoid ☐ R Deltoid

Date: _____Time _____

☐ 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 #_____

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