

# 2020-2021 Seasonal Influenza (Flu) Vaccine Consent Form

## Section 1: Patient Information

Date (MM/DD/YYYY):

|                                             |                                 |                                                                       |                                        |                              |
|---------------------------------------------|---------------------------------|-----------------------------------------------------------------------|----------------------------------------|------------------------------|
| Last Name:                                  | First Name:                     | Prov. Health Number:                                                  | Gender:                                |                              |
| Main Phone Number:                          | Alternate Phone Number:         | Date of Birth (MM/DD/YYYY):                                           | Age:                                   | Child's weight:<br>(kg / lb) |
| Address:                                    | City:                           | Province:                                                             | Postal Code:                           |                              |
| Emergency Contact's Last Name:              | Emergency Contact's First Name: | Relationship:                                                         | Emergency Contact's Main Phone Number: |                              |
| Emergency Contact's Alternate Phone Number: |                                 | Ask your pharmacist about age restriction for flu shots in a pharmacy |                                        |                              |

## Section 2: Screening Questionnaire Refer to Screening Questionnaire Action Guide for recommendations

Yes No

|                                                                                                                                                                                                                                   |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Are you, or have you been <b>sick within the past 3 days?</b> (fever greater than 39.5°C, breathing problems, or active infection)                                                                                                |  |  |
| Have you had difficulty breathing, wheezing or chest tightness within 24 hours of getting an <b>influenza vaccine?</b>                                                                                                            |  |  |
| Are you <b>allergic</b> to any part of the influenza vaccine, or have you had a severe, life-threatening allergic reaction to a past influenza vaccine?                                                                           |  |  |
| Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to:<br>• <b>Contact lens solution • Egg or egg products • Formaldehyde • Gelatin • Gentamicin • Kanamycin • Neomycin • Thimerosal • Polymyxin B</b> |  |  |
| Do you have a serious allergy to <b>latex</b> or <b>natural rubber?</b>                                                                                                                                                           |  |  |
| Have you had a reaction to <b>eggs</b> or <b>egg products</b> but can still eat small amounts of egg? (eg. Stomach ache, skin reaction)                                                                                           |  |  |
| Have you had <b>Guillian-Barré Syndrome</b> within 6 weeks of getting an influenza vaccine? <b>Oculo-Respiratory Syndrome?</b>                                                                                                    |  |  |
| Have you ever had a <b>seizure</b> or have an active, new, or changing <b>neurological disorder?</b>                                                                                                                              |  |  |
| Do you have <b>bleeding problems</b> or use <b>blood thinners?</b> (eg. Warfarin)                                                                                                                                                 |  |  |
| Are you <b>pregnant, nursing</b> , or do you <b>intend to become pregnant?</b>                                                                                                                                                    |  |  |
| Have you received your pneumonia vaccines? If yes, which vaccine _____ and when: _____                                                                                                                                            |  |  |
| Have you received your shingles vaccines? If yes, which vaccine _____ and when: _____                                                                                                                                             |  |  |
| Have you received any <b>vaccines</b> in the last 4 weeks?                                                                                                                                                                        |  |  |
| For children under 18 years old: Is the child using, or will be using an <b>aspirin/aspirin-containing therapy</b> in the next 4 weeks?                                                                                           |  |  |
| Do you have <b>severe asthma</b> (on high dose inhaled or oral corticosteroids) or medically attended <b>wheezing</b> in the past 7 days?                                                                                         |  |  |
| Have you received in the past 48 hours or do you intend to receive in the next 2 weeks <b>flu antiviral therapy?</b> (eg. Oseltamivir)?                                                                                           |  |  |
| Do you have any medical conditions (eg. Cancer, leukemia, HIV/AIDS) or take medications that weaken the <b>immune system?</b>                                                                                                     |  |  |
| Do you provide health care services to or do you have close contact with persons who are <b>immunocompromised?</b>                                                                                                                |  |  |
| Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to Arginine?                                                                                                                                        |  |  |

## Section 3: Consent Given By Patient/Agent

I, the undersigned patient, parent or guardian, have read or have had explained to me information about the seasonal influenza vaccine ("Vaccine") as outlined on the Flu Vaccine Fact Sheet. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the Vaccine. After getting the Vaccine, I agree to wait in the clinic/pharmacy for 15 minutes (or the time recommended by the pharmacist).

I am aware it is possible (yet rare) to have an extreme allergic reaction to any component of the Vaccine. Serious reactions called "anaphylaxis" can be life-threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following vaccination, I am aware it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to treat this reaction and 9-1-1 will be called to provide additional assistance. In the event of anaphylaxis, I, my agent, and/or EMS paramedics will receive a copy of this form. I understand the information contained on this form, may be disclosed to the public health authority and to other required parties for the purpose of adverse event and drug safety reporting.

☐ I confirm that I want to receive the seasonal influenza vaccine **OR** ☐ I confirm that I want my child to receive the seasonal influenza vaccine

|                                     |                         |                          |
|-------------------------------------|-------------------------|--------------------------|
| Patient/Agent Name (& Relationship) | Patient/Agent Signature | Date Signed (MM/DD/YYYY) |
|-------------------------------------|-------------------------|--------------------------|

## PHARMACY USE ONLY Section 4: Prescription Templates Influenza Vaccine Used

### HEALTH CARE PROVIDER'S DECLARATION:

☐ I confirm the above named patient is capable of providing consent for the seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient. I am administering the seasonal influenza vaccine no more than **21 days** after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient.

|                                                                                                                                  |                                                                                                                                                                                     |                                                                                                                                                                                      |                                                                                                                                                                                  |                                                                                              |                                                                                 |                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>AGRIFLU®</b><br>0.5 mL IM<br>DIN 02346850                                                            | <input type="checkbox"/> <b>FLUAD Pediatric®</b><br>0.25 mL IM<br>DIN 02434881                                                                                                      | <input type="checkbox"/> <b>FLUAD®</b><br>0.5 mL IM<br>DIN 02362384                                                                                                                  | <input type="checkbox"/> <b>INFLUVAC®</b><br>0.5 mL IM<br>DIN 02269562                                                                                                           | <input type="checkbox"/> <b>FLUVIRAL®</b><br>0.5 mL IM<br>DIN 02420686                       | <input type="checkbox"/> <b>FLUZONE High-Dose®</b><br>0.5 mL IM<br>DIN 02445646 | <input type="checkbox"/> <b>FLUMIST®</b><br>0.1mL per nostril<br>DIN 02426544 |
| <input type="checkbox"/> <b>FLULAVAL® TETRA</b><br>0.5mL IM<br>DIN 02420783                                                      | <input type="checkbox"/> <b>AFLURIA® TETRA</b><br><input type="checkbox"/> 0.5mL IM pre-filled syringe DIN 02473283<br><input type="checkbox"/> 5mL IM multi-dose vial DIN 02473313 | <input type="checkbox"/> <b>FLUCELVAX® QUAD</b><br><input type="checkbox"/> 0.5mL IM pre-filled syringe DIN 02494248<br><input type="checkbox"/> 5mL IM multi-dose vial DIN 02494256 | <input type="checkbox"/> <b>FLUZONE® QUAD</b><br><input type="checkbox"/> 0.5mL IM single-dose vial DIN 02420643<br><input type="checkbox"/> 5mL IM multi-dose vial DIN 02432730 | <input type="checkbox"/> <b>INFLUVAC® TETRA</b><br>0.5mL IM<br>DIN 02484854                  | <input type="checkbox"/> <b>OTHER</b>                                           |                                                                               |
| Date of Immunization (MM/DD/YYYY):                                                                                               | Time of Immunization:                                                                                                                                                               | Vaccine Lot #:                                                                                                                                                                       | Vaccine Expiry (MM/YYYY):                                                                                                                                                        | Health Care Provider's Name & License #:                                                     | Signature:                                                                      |                                                                               |
| Site of Administration: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Intranasal |                                                                                                                                                                                     | Contacted Primary Prescriber: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               |                                                                                                                                                                                  | Emergency Treatment: <input type="checkbox"/> Yes (see attached) <input type="checkbox"/> No |                                                                                 |                                                                               |
| NS Only                                                                                                                          | Patient condition before:                                                                                                                                                           | Response during:                                                                                                                                                                     |                                                                                                                                                                                  | Response immediately after:                                                                  |                                                                                 |                                                                               |

## Epinephrine Emergency Treatment

|                                                                                                                                                                                     |                       |                                                                                                                                                                                |                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| Pharmacy Name:                                                                                                                                                                      |                       | Pharmacy Address:                                                                                                                                                              |                                       |
| Patient's Last Name:                                                                                                                                                                | Patient's First Name: |                                                                                                                                                                                | Patient's Date of Birth (MM/DD/YYYY): |
| <input type="checkbox"/> EpiPen®<br>0.3mg/0.3mL<br>DIN 00509558   PIN 09857423<br>If weight is >30kg or 66 lbs<br>Expiry date: _____<br>Lot Number: _____                           |                       | <input type="checkbox"/> EpiPen® Junior<br>0.15mg/0.3mL<br>DIN 00578657   PIN 09857424<br>If weight is between 15-30kg or 33-66 lbs<br>Expiry date: _____<br>Lot Number: _____ |                                       |
| Date of Administration (MM/DD/YYYY):                                                                                                                                                |                       | Times of Administration                                                                                                                                                        |                                       |
| Number of Doses Administered:                                                                                                                                                       |                       | 1.<br>2. (if applicable)<br>3. (if applicable)                                                                                                                                 |                                       |
| Health Care Provider's Name & License #:                                                                                                                                            |                       | Signature:                                                                                                                                                                     |                                       |
| Additional Notes (including other emergency measures taken or treatments administered):                                                                                             |                       | Date (MM/DD/YYYY) & Time of Follow-up with Patient/Agent:                                                                                                                      |                                       |
| <b><u>Nova Scotia ONLY:</u></b>                                                                                                                                                     |                       |                                                                                                                                                                                |                                       |
| Patient condition before:                                                                                                                                                           |                       | Response during:                                                                                                                                                               | Response immediately after:           |
| <b><u>Ontario ONLY:</u></b><br>Please attach a copy of the completed flu consent form to be compliant with the documentation requirements set by the Ontario College of Pharmacists |                       |                                                                                                                                                                                |                                       |