2018-2019 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: (kg / lb)
Address:	City:	Province: Postal Code:		Ask your pharmacist about age restrictions for flu shots in a pharmacy.
Emergency Contact's Last Name:	Emergency Contact's First Name:	Relationship:		
Contact's Main Phone Number:	Contact's Alternate Phone Number:	Alberta residents: Are you a healthcare worker? ☐ Yes ☐ No		

Section 2: Screening Questionnaire

Refer to Screening Questionnaire Action Guide for recommendations

	Yes	No	Unsure
Are you, or have you been **sick within the past 3 days**? (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 **influenza vaccine**?			
Are you **allergic** 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: • **Contact lens solution** • **Egg or egg products** • **Formaldehyde** • **Gelatin** • **Gentamicin** • **Kanamycin** • **Neomycin** • **Thimerosal**			
Do you have a serious allergy to **latex** or **natural rubber**?			
Have you had a reaction to **eggs** or **egg products** but can still eat small amounts of egg? (eg. Stomach ache, skin reaction)			
Have you had **Guillian-Barré Syndrome** within 6 weeks of getting an influenza vaccine? **Oculo-Respiratory Syndrome**?			
Do you have an active, new, or changing **neurological disorder**?			
Have you ever had a **seizure**?			
Do you have **bleeding problems** or use **blood thinners** (eg. Warfarin)			
Are you **pregnant**, **nursing**, or do you **intend to become pregnant**?			
Additional Questions for Live Attenuated Intranasal Vaccine (FluMist): Have you received any **vaccines** in the last 4 weeks?			
For children under 18 years old: Is the child using, or will be using an **aspirin/aspirin-containing therapy** in the next 4 weeks?			
Do you have **severe asthma** (on high dose inhaled or oral corticosteroids) or medically attended **wheezing** in the past 7 days?			
Do you have any medical conditions (eg. Cancer, leukemia, HIV/AIDS) or take medications that weaken the **immune system**?			
Have you received **blood transfusion(s)/product(s)** in the last year?			
Have you received in the past 48 hours or do you intend to receive in the next 2 weeks **flu antiviral therapy**? (eg. Oseltamivir)			
Do you provide health care services to or do you have close contact with persons who are **immunocompromised**?			
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.

Trivalent Influenza Vaccine (TIV):	☐ **AGRIFLU®** 0.5 mL IM DIN 02428881	☐ **FLUAD®** 0.5 mL IM DIN 02362384	☐ **FLUAD Pediatric®** 0.25 mL IM DIN 02434881	☐ **FLUVIRAL®** 0.5 mL IM DIN 02420686	☐ **FLUZONE High-Dose®** 0.5 mL IM DIN 02445646	☐ **INFLUVAC®** 0.5 mL IM DIN 02269562	☐ **VAXIGRIP®** 0.5 mL IM DIN 02367718

Quadrivalent Influenza Vaccine (QIV):	☐ **FLULAVAL™ TETRA** 0.5mL IM DIN 02420783	☐ **FLUZONE® QUADRIVALENT** 0.5mL single-dose vial DIN 02420643 5mL multi-dose vial DIN 02432730	**Live Attenuated Influenza Vaccine (LAIV):**	☐ **FLUMIST®** 0.1mL per nostril (0.2mL total dose intra-nasally) DIN 02426544

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: ☐ Left Arm ☐ Right Arm ☐ Intranasal	Contacted Primary Prescriber: ☐ Yes ☐ No	Emergency Treatment: ☐ Yes (see attached) ☐ No

Epinephrine Emergency Treatment

Patient's Last Name:	Patient's First Name:	Patient's Date of Birth (MM/DD/YYYY):

☐ EpiPen®
0.3mg/0.3mL
DIN 00509558 | PIN 09857423
If weight is >30kg or 66 lbs

☐ EpiPen® Junior
0.15mg/0.3mL
DIN 00578657 | PIN 09857424
If weight is between 15-30kg or 33-66 lbs

Date of Administration (MM/DD/YYYY):	Times of Administration 1. 2. (if applicable) 3. (if applicable)
Number of Doses Administered:	
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: