2021-2022 Seasonal Influenza (Flu) +/- COVID Vaccine Consent Form

Section 1: Patient Information

Last Name:	First Name:	Prov. Health Number:	Gender: Male ☐ Female ☐	Age:
Phone Number:	Date of Birth (MM/DD/YYYY):	Emergency Contact Name and Phone Number:		
Address:	City:	Province:	Postal Code:	

Section 2: Screening Questionnaire

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 or difficulty breathing, sore throat, runny nose, feeling unwell?	☐ Yes ☐ No
Have you ever had a reaction to any immunization previously (eg. hives, fainting, difficulty breathing)?	☐ Yes ☐ No
Do you have allergies to medications, food (eg. eggs), vaccine components or latex?	☐ Yes ☐ No
Do you take any medications that suppress your immune system or are you immunocompromised?	☐ Yes ☐ No
Do you take a blood thinner or have a bleeding disorder?	☐ Yes ☐ No
Do you have a history of Oculo-Respiratory Syndrome?	☐ Yes ☐ No
Do you have a history Guillain-Barre Syndrome within 6 weeks of getting a flu shot?	☐ Yes ☐ No
Are you pregnant, nursing, or do you intend to become pregnant?	☐ Yes ☐ No

Have you received a full COVID-19 vaccine course? ☐Yes ☐ No Shingles vaccine? ☐Yes ☐ No Pneumonia vaccine? ☐Yes ☐ No

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

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

PHARMACY USE ONLY Section 4: Vaccine Documentation

AFLURIA® TETRA ☐ 0.5mL IM pre-filled syringe DIN 02473283 ☐ 0.5mL IM 5mL multi-dose vial DIN 02473313	☐ **FLUAD Pediatric®** 0.25mL IM DIN 02434881	☐ **FLUAD®** 0.5mL IM DIN 02362384	☐ **FLUZONE® High-Dose QUAD** 0.7mL IM DIN 02500523	☐ **FLUVIRAL®** 0.5mL IM DIN 02420686	☐ **COVID Vaccine/Other Inactivated Vaccine**
FLUZONE® QUAD ☐ 0.5mL IM single-dose vial DIN 02420643 ☐ 0.5mL IM 5mL multi-dose vial DIN 02432730	☐ **FLULAVAL® TETRA** 0.5mL IM DIN 02420783	**FLUCELVAX® QUAD** ☐ 0.5mL IM pre-filled syringe DIN 02494248	☐ **FLUMIST® QUAD** 0.1mL per nostril DIN 02426544	☐ **INFLUVAC® TETRA** 0.5mL IM DIN 02484854	

Flu Vaccine	Lot #:	Expiry Date (MM/YYYY):	Site of Administration: ☐ Left Arm ☐ Right Arm ☐ Intranasal	Time of Immunization:	Date of Immunization (MM/DD/YYYY):
Vaccine #2	Lot #:	Expiry Date (MM/YYYY):	Site of Administration: ☐ Left Arm ☐ Right Arm	Time of Immunization:	

Health Care Provider's Name and License Number:	Health Care Provider's Signature:

NS Only	Patient condition before:	Response during:	Response immediately after: