2020/2021 INFLUENZA VACCINE CONSENT FORM

1. PATIENT INFORMATION

Name _____ Emergency Contact Name _____

Date of Birth _____ Emergency Contact Phone _____

Phone Number _____

Personal Health Number_____

2. COVID-19 SCREENING AND HEALTH INFORMATION

As of today:	Yes	No
Are you experiencing cold, flu, or COVID-19-like symptoms, **even mild ones**? Symptoms include: fever, chills, cough, shortness of breath, sore throat/painful swallowing, stuffy/runny nose, loss of sense of smell, headache, muscle aches, fatigue, loss of appetite, conjunctivitis, dizziness, confusion, nausea, vomiting, abdominal pain, skin rashes, discolouration of fingers or toes - or **any other suspected COVID-19 symptoms**?		
Have you travelled to any countries outside Canada (including the United States) within the last 14 days?		
Within the last 14 days, did you **provide care** or had **close contact** with a person with confirmed COVID-19 or someone who is under investigation for COVID-19?		
Have you ever had a flu shot before?		
Have you received any vaccinations in the last 6 weeks?		
Have you ever fainted or had a serious reaction to any previous injection or vaccine(s) including Guillain- Barre Syndrome?		
Do you have any allergies? Please list: (foods, medications, vaccine components)		
Do you have any chronic health conditions or immunodeficiencies? Please list:		
Are you currently on any medications or immunosuppressants? Please list:		
Do you have an active neurological condition?		
Are you pregnant or breastfeeding?		
Have you received blood products (containing immunoglobulin) in the last 3 months?		

3. PATIENT CONSENT

- I have read or had explained to me and understand the benefits, side effects and risks of receiving and risks of not receiving the influenza vaccine.
- I have had the opportunity to ask questions and I have received satisfactory answers.
- I agree to stay in the pharmacy for at least 15 minutes after receiving the influenza vaccine or as directed by the pharmacists.
- I authorize my pharmacist to notify my physician/nurse practitioner and/or public health of the vaccine received, any adverse events experienced and/or to contact me with any follow-up if needed. I consent to receive the influenza vaccine today
- OR I consent on behalf of the patient to receive the influenza vaccine today

Print Name _____ Signature _____

Date _____ Relationship (if applicable) _____

4. VACCINE INFORMATION PHARMACIST USE ONLY:

Pharmacy Name: Pharmasave Parksville Phone Number: (250) 951-0227

Influenza Vaccine			**Notes/Observations** (15-30min wait)
Agriflu Fluad Fluviral Influvac FluLaval Tetra Other:	**Dose**	0.5 mL	
	Administration Route	Intramuscular	
Pharmacist Signature:	**Administration Site**	Deltoid R L	