

2021/2022 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)
FluZone	Afluria Tetra	Dose	0.5 mL
FluLaval Tetra	Flumist	Administration Route	Intramuscular
Other:			
Pharmacist Signature:		Administration Site	Deltoid R L