VACCINATION CONSENT FORM

Patient Name First _____ Last _____

Address _____

_____

Date of Birth (dd/mm/yyyy) _____ Phone Number _____

Emergency Contact Name _____ Phone Number _____

PHN _____

NOTE: Under provincial legislation pharmacists cannot give injections to children under 5.

Gender ☐ M ☐ F ☐ X

Please answer the following questions:

As of today:	**Yes**	**No**
Are you experiencing any cold, flu or COVID-19-like symptoms, **even mild ones**? Symptoms include: fever, chills, cough, shortness of breath, sore throat and painful swallowing, stuffy or runny nose, loss of sense of smell, headache, muscle aches, fatigue or loss of appetite.		
Have you travelled to any countries outside Canada (including the United States) within the last 14 days?		
Did you **provide care** or have **close contact** with a person with confirmed COVID-19?		
When was your last tetanus vaccine? _____		
Patients over 50 – Have you ever received a shingles vaccine?		
Patients over 65 – Have you ever received a pneumococcal vaccine?		
Is this the first time you are receiving this vaccine?		
Have you ever fainted or had a serious reaction to any previous injection or vaccine(s)?		
Have you received any vaccinations in the last 6 weeks?		
Do you have a fever, infection or feel unwell?		
Do you have any allergies? Please list:		
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?		
Do you have any bleeding disorders or are you taking any blood-thinners?		
Are you pregnant or breastfeeding?		
Have you received blood products (containing immunoglobulin) in the last 3 months?		

- Side effects from vaccination typically resolve within 2 to 3 days and, in most cases, an analgesic (pain killer) such as acetaminophen (Tylenol®) or ibuprofen (Advil® or Motrin®) may be taken to reduce fever and/or discomfort.
- Common side effects: soreness, tenderness, redness and/or swelling in the area of the injection site.
- Less frequent side effects: mild fever, headache and/or muscle aches.
- Due to a very rare possibility of an allergic or other reaction (about 1 for every one million vaccinations), please remain in the pharmacy for monitoring for at least 15 minutes after your vaccination.
- If you develop a high fever or unexpected or prolonged side effects (lasting more than 2 days after vaccination), contact your doctor promptly.

Please indicate your consent to the following:

☐ I have read and understood the information provided to me regarding the benefits, side effects and risks associated with the following vaccinations (as indicated on the back of this form) administered today.

☐ I have had the opportunity to have my questions answered.

☐ I/my dependent, agree(s) to remain at the pharmacy for at least 20 minutes following vaccination.

☐ I authorize my pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction.

☐ I authorize my pharmacist to contact me about a follow-up dose if required.

Print Name _____ Signature _____

Date _____

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