

Section 1: Personal Information

Patient First and Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No:	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age:	Child's Weight: kg or lb
			Date of Birth (MM/DD/YYYY)
Name of Emergency Contact:		Contact's Daytime Phone Number:	
Emergency Contact's Relationship to Patient:		Contact's Evening/Other Phone Number:	

Section 2: COVID-19 Screening

Note: Every individual who will be present during the administration of the vaccine (regardless of whether you are receiving a vaccine or not) should be screened for COVID-19.

Have you travelled outside of Canada in the past 14 days?

Yes No

Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate personal protective equipment?

Yes No

Are you experiencing any of the following symptoms?

- Fever
- New onset of cough
- Worsening chronic cough
- Shortness of breath
- Difficulty breathing
- Sore throat
- Difficulty swallowing
- New or unusual worsening of chronic conditions
- Low blood pressure for your age
- Decrease or loss of sense of taste or smell
- Chills
- Headaches
- Unexplained fatigue/lethargy/malaise/muscle aches (myalgias)
- Nausea/vomiting, diarrhea, abdominal pain
- Pink eye (conjunctivitis)
- Runny nose or nasal congestion without other known cause
- Fast heart rate
- For infants and young children: decreased or lack of appetite/difficulty feeding

Yes No

If you are older than 70 years of age, are you experiencing any of the following symptoms?

- Delirium
- Unexplained or increased number of falls
- Acute functional decline

Yes No

If you respond YES to **ANY** of the screening questions in Section 2, you should not receive a flu shot at the pharmacy at this time and should speak with your pharmacist.

If the responses to **ALL** of the screening questions in Section 2 are **NO**, proceed to Section 3.

Section 3: Screening Questionnaire

For adult patients as well as parents of children (≥ 5 years of age) to be vaccinated:

The following questions will help us determine if there is any reason you or your child should not get the flu shot today. If you answer “yes” to any question, it does not necessarily mean the shot cannot be given. It simply means additional questions must be asked.

If a question is not clear, please ask your pharmacist to explain it.

Please answer the following questions	Yes	No	Unsure	Action required
Are you sick today? (fever greater than 39.5°C, breathing problems, or active infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES , do NOT get the shot today
Are you allergic to any medications including vaccines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES , list what you are allergic to here:
Are you allergic to any of the following? Check all that apply: <input type="checkbox"/> Thimerosal <input type="checkbox"/> Egg protein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES , your pharmacist can check whether the flu shot contains any of these potential allergens and use one which does not.
Are you allergic to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES or UNSURE , do NOT get the shot & SPEAK WITH YOUR MD
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a reaction to eggs or egg products ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES or UNSURE , speak to the pharmacist, you may be able to receive the flu shot but <u>may require a longer observation period post-administration.</u>
Do you have any serious allergy to latex or natural rubber?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES or UNSURE , you can receive the flu shot but non-latex materials are to be used
Have you had Guillain-Barré Syndrome within 6 weeks of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES , do not get the flu shot and SPEAK WITH YOUR MD
Do you have a new or changing neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES , do not get the flu shot & SPEAK WITH YOUR MD
Do you have bleeding problems or use blood thinners? (e.g. warfarin, low dose or regular strength aspirin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If YES , shot can be given but apply gentle pressure afterwards

Seasonal Influenza Vaccine
Consent Form and Rx Template 2020-21

Section 4: Consent Given By Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the [Flu Shot 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 flu shot. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu shot.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips.

In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

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)
PHARMACIST DECLARATION: I confirm the above named patient/agent is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient.		
Pharmacist Signature	OCP License #	Date Signed (MM/DD/YYYY)

Section 5: Prescription Templates – Pharmacy Use Only

INFLUENZA VACCINE			EPINEPHRINE EMERGENCY TREATMENT	
Patient Name:			Patient Name:	
<input type="checkbox"/> FLULAVAL TETRA – DIN 02420783 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial			<input type="checkbox"/> EpiPen® DIN 00509558 – Note: Use the PIN 09857423 for EpiPen claims for adverse events within the UIIP	
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02432730 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial				
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02420643 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe			<input type="checkbox"/> EpiPen Junior® DIN 00578657 – Note: Use the PIN 09857424 for all EpiPen Junior claims for adverse events within the UIIP	
<input type="checkbox"/> FLUCELVAX® QUAD – DIN 02494248 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe			<input type="checkbox"/> Allerject® 0.3 mg/0.3 mL DIN 02382067 – Note: Use the PIN 09857440 for Allerject 0.3 mg/0.3 mL claims for adverse events within the UIIP	
<input type="checkbox"/> FLUZONE® HIGH-DOSE – DIN 02445646 – HD-TIV 60 mcg/0.5 mL – 0.5 mL (single-dose) syringe			<input type="checkbox"/> Allerject® 0.15 mg/0.15 mL DIN 02382059 – Note: Use the PIN 09857439 for Allerject 0.15 mg/0.15 mL claims for adverse events within the UIIP	
			<input type="checkbox"/> Emerade™ 0.5 mg/0.5 mL DIN 02458454 – Note: Use the PIN 09858130 for Emerade 0.5 mg/0.5 mL claims for adverse events within the UIIP	
			<input type="checkbox"/> Emerade™ 0.3 mg/0.3 mL DIN 02458446 – Note: Use the PIN 09858129 for Emerade 0.3 mg/0.3 mL claims for adverse events within the UIIP	
Vaccine Lot #:		Expiry (MM/YYYY):	Number of Doses Administered:	
Date of Immunization:		Time of Immunization:	Date of Administration:	Time(s) of Administration: 1. 2. (if applicable) 3. (if applicable)
Dose	Route IM	Site of administration <input type="checkbox"/> Left: _____ <input type="checkbox"/> Right: _____	Administering Pharmacist Name and OCP #:	Administering Pharmacist Signature:
Administering Pharmacist Name and OCP #:			Additional Notes (including other emergency measures taken or treatments administered):	
Administering Pharmacist Signature:			Date & Time of Follow-up with Patient/Agent:	