INFLUENZA VACCINE CONSENT FORM

1. PATIENT INFORMATION

Patient Full Name: _____ Birth Date (mm/dd/yyyy): _____

Address: _____ Emergency Contact Name: _____

Phone Number: _____ Emergency Contact Phone Number: _____

Health Card Number: _____ Physician / Nurse Practitioner: _____

Gender (optional): _____ Physician / NP Phone Number: _____

2. HEALTH INFORMATION AND SCREENING

As of today:	Yes	No
Do you have a fever, infection, cough, shortness of breath, chest pain or feel unwell		
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, latex, 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

As of today:	Yes	No
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 pharmacist/nurse.		
I authorize my pharmacist/nurse 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.		

AND:

☐ I consent to receive the influenza vaccine today ***OR*** ☐ I consent on behalf of the patient to receive the influenza vaccine today

Print Name _____ Relationship (if applicable) _____

Date _____ Phone Number _____

Signature _____

OR ☐ Verbal consent provided by patient/agent (circle) Consent given to _____

4. VACCINE INFORMATION – PHARMACY USE ONLY:

Pharmacy Name _____ Pharmacy Phone Number _____

Influenza Vaccine Dosage: ☐ 0.5mL ☐ Other	**Administration Site**	Deltoid: ☐ R ☐ L ☐ Other	**Notes/Observations** (15 - 30 minute wait)
☐ Fluad ☐ Flulaval Tetra ☐ FluMist Quadrivalent ☐ Fluviral ☐ Fluzone HD Quadrivalent ☐ Fluzone Quadrivalent ☐ Other	**Administration Route**	☐ IM ☐ Intranasal	
	Immunization Date		
	Immunization Time	☐ ☐ AM ☐ PM	
	Pharmacist/Health Care Provider Name		
Lot No.	**License No.**		
Expiry Date	**Signature**		

Communication to other Health Care Providers (physician, nurse practitioner, public health) via: ☐ Fax ☐ Electronic Provincial Registry