

# PHARMASAVE<sup>®</sup> Influenza Vaccination Patient Screening and Consent

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Weight: \_\_\_\_\_ Health Card #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Tel: \_\_\_\_\_  
 Physician/Nurse Practitioner Name: \_\_\_\_\_ Physician/NP Tel: \_\_\_\_\_

As of today, COVID-19 Screening:	Yes	No
Do you feel unwell today, have a fever or a cough (new or worsening), shortness of breath, or difficulty breathing?		
Do you have any of the following symptoms: runny nose/nasal congestion, sore throat, difficulty swallowing, chills, headache, new onset fatigue, new onset muscle pain, nausea/vomiting, diarrhea, pink eye, loss of taste or smell?		
<b>Ontario only:</b> >70y.o. with delirium, unexplained or increased number of falls, worsening chronic conditions?		
Have you travelled outside of Canada/Atlantic Canada within the last 14 days?		
Have you been in contact with someone that has tested positive for COVID 19 in the past 14 days?		
<input type="checkbox"/> REFERRED TO 811 (Atlantic) / TELEHEALTH (Ontario); PATIENT DID NOT RECEIVE IMMUNIZATION		
As of today, Pre-Immunization Assessment:	Yes	No
Is this the first time you are receiving an influenza vaccine?		
Have you ever fainted or had a serious reaction (including anaphylaxis) to any previous injection or vaccine(s)? If yes, please describe the reaction:		
Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving an influenza vaccine?		
Do you have an allergy to any of the following? Please check all that apply: <input type="checkbox"/> Latex <input type="checkbox"/> Thimerosal <input type="checkbox"/> Formaldehyde <input type="checkbox"/> Triton®X100 <input type="checkbox"/> Neomycin <input type="checkbox"/> Kanamycin <input type="checkbox"/> Gentamycin <input type="checkbox"/> Polysorbate 80 <input type="checkbox"/> CTAB (Cetyltrimethylammonium Bromide) <input type="checkbox"/> Sodium Deoxycholate <input type="checkbox"/> Sucrose		
Do you have an egg allergy? (For monitoring purposes)		
Do you have any allergies to any medications? If yes, please list:		
Do you have any chronic health conditions <b>OR</b> conditions which may lower your immunity? (e.g.: asthma, diabetes, HIV, cancer, bleeding disorders) If yes, please list:		
Are you currently on any medications (prescriptions, non-prescription, herbal products etc.) <b>OR</b> are you taking any treatment that lowers immunity (prednisone, radiotherapy, chemotherapy) <b>OR</b> taking any blood thinners? If yes, please list:		
Are you pregnant?		

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- My pharmacist has reviewed with me the benefits, side effects, risks (including risks of not receiving vaccine) associated with the influenza vaccine being administered today.
- I have had the opportunity to have my questions answered.
- I/my dependent, agree to remain at the pharmacy for at least 15-30 minutes following administration of the medications/ vaccine or as directed by the pharmacist. (Egg allergy requires 30 minutes.)
- I authorize my pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction and to notify my emergency contact person.
- I authorize my pharmacist to notify my physician/nurse practitioner and/or public health of the vaccine received and to contact me with any follow-up if needed.

I consent to receive the influenza vaccine today

I consent for my child/dependent to receive the influenza vaccine today

Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_

(Guardian/ agent as required)

Date: \_\_\_\_\_

## PHARMACIST DOCUMENTATION

<input type="checkbox"/> Fluzone MDV DIN 02432730 <input type="checkbox"/> Fluzone PFS DIN 02420643 <input type="checkbox"/> FluLaval Tetra DIN 02420783 <input type="checkbox"/> Fluzone High-Dose DIN 02445646 <input type="checkbox"/> Flucelvax Quad DIN 02494248 <input type="checkbox"/> Other: _____	<b>Dose:</b> _____	<b>Lot:</b> _____	<b>Exp (mm/dd/yy):</b> _____
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<b>Route:</b> <input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<b>Injection Site:</b> Deltoid <input type="checkbox"/> Left <input type="checkbox"/> Right
<b>Date (mm/dd/yy):</b> _____	<b>Time:</b> _____ AM / PM

### Patient monitoring and follow up:

**15-30 minutes post injection:**  Patient appears fine, no adverse reaction(s)

Comments:

Pharmacy Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Pharmacist / Pharmacy Technician Name: \_\_\_\_\_

Lic #: \_\_\_\_\_ Signature: \_\_\_\_\_

Communication to other Health Care Providers (physician, nurse practitioner, public health) via

Fax  DIS