

2020/2021 INFLUENZA VACCINE CONSENT FORM

1. PATIENT INFORMATION

Patient Full Name _____ Date of Birth _____
 Address _____ Age _____
 Emergency Contact _____ Weight _____
 Emergency Contact Phone Number _____ Phone Number _____
 Physician/ Nurse Practitioner _____ Health Card Number _____
 Physician/NP Phone Number _____ Gender _____

2. COVID SCREENING AND HEALTH INFORMATION

As of today:	Yes	No
Do you have a fever, infection, shortness of breath, chest pain or feel unwell		
Are you experiencing 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, conjunctivitis, dizziness, confusion, nausea, vomiting, abdominal pain, skin rashes, discolouration of fingers or toes - or any other suspected COVID-19 symptom ?		
Have you travelled to any countries outside Canada (including the United States) within the last 14 days? Manitoba residents - have you travelled outside of Manitoba within the last 14 days?		
Within the last 14 days, did you provide care or have 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.

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 _____

Signature _____

Date _____

Relationship (if applicable) _____

Phone Number _____

4. VACCINE INFORMATION

PHARMACIST USE ONLY:

Pharmacy Name _____ Pharmacy Phone Number _____

Influenza Vaccine Dosage: 0.5mL Other	Administration Site	Deltoid: R L Other	Notes/Observations (15-30min wait)
Afluria Agriflu Flulaval Fluzone Fluzone HD Influvac	Administration Route	IM Intranasal Intradermal	
Other	Immunization Date		
	Immunization Time		
Lot No.	Pharmacist Name		
	RPh License No.		
Expiry Date	RPh Signature		

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

- Fax
- Electronic Provincial Registry