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 (under 7 in MB).

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 15 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 ______________________

FOR VACCINATING PHARMACIST ONLY

Patient Name ____

Vaccination	Trade Name / Lot No. / Expiry Date	Dosage (circle)	Dosage Form (check)	Dose Number (check) / Initial	Next Dose Schedule (# months after 1st dose)
Hepatitis A	Trade Name __________ Lot No ______________ Expiry Date __________	1 - 18 yrs: 0.5 mL 19+ yrs: 1.0 mL	☐ IM	☐ 1 __________ ☐ 2 __________	Dose 2: 6 months Date: ______________
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		
Hepatitis B	Trade Name __________ Lot No ______________ Expiry Date __________	1 - 18 yrs: 0.5 mL 19+ yrs: 1.0 mL	☐ IM	☐ 1 __________ ☐ 2 __________ ☐ 3 __________	Dose 2: 1 month Dose 3: 6 months Date: ______________
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		
Hepatitis A & B	Trade Name __________ Lot No ______________ Expiry Date __________	Twinrix: 1.0 mL Twinrix Jr: 0.5 mL	☐ IM	☐ 1 __________ ☐ 2 __________ ☐ 3 __________	Dose 2: 1 month Dose 3: 6 months Date: ______________
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		
Pneumococcus	Trade Name __________ Lot No ______________ Expiry Date __________	All ages: 0.5 mL	☐ IM ☐ SC	☐ 1 __________ ☐ 2 __________	Date: ______________
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		
Human Papilloma Virus	Trade Name __________ Lot No ______________ Expiry Date __________	9 - 26 yrs: 0.5 mL	☐ IM	☐ 1 __________ ☐ 2 __________ ☐ 3 __________	Dose 2: 2 months Dose 3: 6 months Date: ______________
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		
Herpes Zoster (shingles)	Trade Name __________ Lot No ______________ Expiry Date __________	50 yrs +	☐ IM ☐ SC	☐ 1 __________ ☐ 2 __________	☐ Primary dose only ☐ Dose 2: 2-6 months Date: ______________
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		
Influenza	Trade Name __________ Lot No ______________ Expiry Date __________	All ages: 0.5 mL	☐ IM ☐ Nose	☐ 1 __________ ☐ 2 __________	Dose 2: 1 month (only if <9 yrs & previously unvaccinated)
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		
Other:	Trade Name __________ Lot No ______________ Expiry Date __________				
Date & time of vaccination ________________________________			Site: ☐ Left arm ☐ Right arm ☐ ____________		

Checklist:

- ☐ Obtained signed informed consent from patient (purpose of vaccine, risks vs. benefits)
- ☐ Patient has remained in the pharmacy for at least 15 minutes
- ☐ Patient understands common side effects and how to seek help if adverse reactions persist
- ☐ Patient has a copy of updated immunization records
- ☐ Patient has no visible or declared symptoms of COVID-19
- ☐ Patient has documentation of next dose schedule: ____________________ (mm/dd/yyyy)

______________________________	______________________________	______________________________
Vaccinating Pharmacist/HCP Name	**License Number**	**Signature**

VCE-01 / Aug 2020