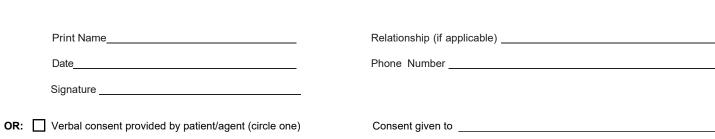
## 2022/2023 INFLUENZA VACCINE CONSENT FORM

1. PATIENT INFORMATION							
Patient Full Name	Birth Date						
Address		Emergency Contact					
Phone Number	Emergency Contact Phone Number						
Health Card Number	Physician/ Nurse Practitioner						
Gender	Physician/NP Phone Number						
2. COVID SCREENING AND HEALTH INFOR	RMATION						
As of today:		Yes	No				
Do you have a fever, infection, shortness of breath, ch	nest pain or feel unwell						
shortness of breath, sore throat and painful swallowing	otoms, even mild ones? Symptoms include: fever, chills, cough, g, stuffy or runny nose, loss of sense of smell, headache, muscle ness, confusion, nausea, vomiting, abdominal pain, skin r suspected COVID-19 symptom?						
Have you had a COVID-19 test in the past 14 days? I	f yes, please enter date and result.						
Within the last 14 days, did you <b>provide care</b> or have or someone who is under investigation for COVID-19	close contact with a person with confirmed COVID-19						
Have you ever had a flu shot before?							
Have you received any vaccinations in the last 6 week	s?						
Have you ever fainted or had a serious reaction to any Barre Syndrome?	previous injection or vaccine(s) including Guillain-						
Do you have any allergies? Please list: (foods, medica	ations, latex, vaccine components)						
Do you have any chronic health conditions or immuno	deficiencies? Please list:						
Are you currently on any medications or immunosupp	ressants? Please list:						
Do you have an active neurological condition?							
Are you pregnant or breastfeeding?							
Have you received blood products (containing immuno	oglobulin) in the last 3 months?						
<ul> <li>I have had the opportunity to ask questions and I ha</li> <li>I agree to stay in the pharmacy for at least 15 minut</li> <li>I authorize my pharmacist/nurse to notify my physicial events experienced and/or to contact me with any forms.</li> </ul>	es after receiving the influenza vaccine or as directed by the pharma an/nurse practitioner and/or public health of the vaccine received, any follow-up if needed.	acist/nu y adver	ırse. se				
AND: Laconsent to receive the influenza vaccine today	OR	vaccine	today				





## 4. VACCINE INFORMATION

## **PHARMACY USE ONLY:**

Pharmacy Name	_Pharmac	Pharmacy Phone Number				
Influenza Vaccine Dosage 0.5mL Other	Administration Site	Deltoid:	R	L	Other	Notes/Observations (15-30 min wait)
Afluria Tetra	Administration Route	IM		Intranasal		
Fluad	Immunization Date					
Flulaval Tetra	Immunization Time			AM	PM	
FluMist Quadrivalent	Pharmacist/Nurse Name					
Fluzone HD Quadrivalent						
Fluzone Quadrivalent						
Other						
Lot No.	License No.					
Expiry Date	Signature					
Communication to other Health Care Providers (p	ohysician, nurse practitio	oner, public	c heal	th) via:		
☐ Electronic Provincial Registry						

