VACCINATION/INJECTION CARE AND CONSENT FORM

Patient Name First _____ Last _____

Address _____

_____

Date of Birth _____ Phone Number _____

Emergency Contact Name _____ Phone Number _____

Health Card Number _____

Gender _____

NOTE: Under provincial legislation pharmacists cannot give injections to children under a certain age. Check with your pharmacist on the age restrictions in your province.

Please answer the following questions (patient):

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.	☐	☐
Which vaccines have you had in the past? ☐ Tetanus/Diphtheria Date _____ ☐ Pneumococcal Date _____ ☐ Shingles Date _____ ☐ Chickenpox Date _____ ☐ MMR Date _____ ☐ Other _____ Date _____		
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?	☐	☐
Have you received any vaccinations/injections in the last 6 weeks? Or have any scheduled vaccines in the upcoming weeks?	☐	☐
Do you have any allergies? (food, medications, environmental, latex, thimerosal, formaldehyde, Triton®X100, neomycin, kanamycin, gentamycin, polyethylene glycol (PEG), polysorbate 80, CTAB (cetyltrimethylammonium bromide), sodium deoxycholate, sucrose, etc.) Please list: _____	☐	☐
Do you have any chronic health conditions or immunodeficiencies? Please list: _____	☐	☐
Are you currently on any medications, or immunosuppressants or antiviral medications or antibiotics? (including over-the-counter items) 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?	☐	☐
If you will be receiving a COVID-19 vaccine: Have you had a previous COVID-19 infection? If yes, were you treated with convalescent plasma or monoclonal antibodies (e.g., Sotrovimab, Casirivimab, Imdevimab) in the last 90 days? _____	☐	☐
Do you have a history of ☐ myocarditis or ☐ pericarditis ☐ multisystem inflammatory syndrome in children (MIS-C)		
If you will be receiving a live vaccine: Do you require a TB skin test within the next 4 weeks, or have you ever had a positive TB skin test?	☐	☐
Do you have close contact with anyone with a weakened immune system?	☐	☐
In the past year, have you received a transfusion of blood/blood products, or immune globulin (Ig)?	☐	☐
For Manitoba only: Reason for immunization (check ONE only) ☐ Personal care home resident ☐ Community with disproportionate disease impact ☐ Healthcare worker (all settings) ☐ Other congregate living (includes residents, non-health care staff, visitors, volunteers) ☐ Routine (age) **Health care workers only – indicate your primary work setting:** ☐ Long-term care/PCH ☐ Community ☐ Acute ☐ Print your facility/office name: _____		

Information:

- 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, 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/injections 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/injection.
- ☐ 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 notify my physician of the vaccine(s)/injection(s) received and to contact me about a follow-up dose if required. I understand the information will be used and disclosed in accordance with the Freedom of Information and Protection of Privacy Act and that summary statistical information may be reported to the Ministry of Health.
- ☐ I am responsible for any associated costs for service(s) (if applicable).

I hereby give my consent (for myself, child, or dependent) to receive the vaccinations/injections today and release Pharmasave #_____ and the vaccinating/injecting pharmacist/healthcare professional _____ from any and all liability.

Print Name _____ Signature _____

Date _____ Signature of: ☐ vaccine recipient ☐ parent/guardian ☐ proxy

☐ Verbal consent given to pharmacist/healthcare provider

FOR VACCINATING PHARMACIST /HEALTH CARE PROVIDER USE ONLY

Patient Name ______________________________ PHN __________________________________ DOB ____________________

Vaccination	**Trade Name / Lot No. / Expiry Date**	**Dosage (mL)**	**Dosage Form**	**Dose Number**	**Next Dose Schedule**
Affix prescription label here	Trade Name ___________ DIN _________________ Lot No ________________ Expiry Date ____________		☐ IM ☐ SC		Dose: __________ Date: __________
Date of vaccination _____________ Time of vaccination ____________________ Patient response to vaccination:______________________________________			Site location: ☐ Left arm ☐ Right arm		

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Date of vaccination _____________ Time of vaccination ____________________ Patient response to vaccination:______________________________________			Site location: ☐ Left arm ☐ Right arm		

Pharmacist Checklist:

- ☐ Obtained signed informed consent from patient (purpose of vaccine, risks vs benefits, etc.)
- ☐ Patient has remained in the pharmacy for at least 15 minutes
- ☐ Patient has documentation of next dose schedule: _____
- ☐ Concerns and questions addressed
- ☐ Patient understands common side effects and how to seek help if adverse reactions persist
- ☐ Document on patient's record: Patient has a copy of updated immunization record (proof of vaccination)
- ☐ Document on patient's record: Notified patient's primary care provider

For Manitoba only:

The following five interventions must be performed and documented with a checkmark by the immunization provider:

- ☐ Fact sheet(s) provided
- ☐ Health history completed and reviewed
- ☐ Expected benefits and material risks of vaccine provided
- ☐ Information provided about reporting vaccine side effects (reportable side effects pursuant to section 57(2) of the Public Health Act)
- ☐ Concerns and questions addressed

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

Affix Prescription Hard Copy Here

PHARMASAVE®