Rx PharmaChoice

CONSENT FOR INFLUENZA VACCINE ADMINISTRATION

Patient Name: _____ **Physician:** _____

ON Health Card Number: _____ **Date of Birth:** _____

Phone#: _____ **Address:** _____

Please answer the following questions:	**YES**	**NO**
1. Have you been vaccinated against influenza before?		
2. Are you sick today? *(i.e. fever, cold, infection)*		
3. Do you have any allergies? *(i.e. latex, eggs, gelatin, antibiotics)*		
4. Do you have any health conditions?		
5. Do you have any conditions or take medication which may compromise your immune system?		
6. Do you have any bleeding disorders or take blood thinners?		
7. Have you had a reaction to a vaccine in the past? Allergic Reactions or Guillain-Barre Syndrome		
8. Are you pregnant, trying to conceive or breastfeeding?		
9. Have you had a mastectomy? If yes, ☐ Left ☐ Right		

Optional Screening Questions: *Your answers to these questions help the pharmacist determine your current immunization status and assist in providing adult vaccine recommendations.*	**YES**	**NO**
1. If you are 50 years or older, have you received a Shingles vaccine in the past?		
2. If you are 50 years or older, have you received a Pneumococcal vaccine in the past?		
3. Would you like to speak to a pharmacist about these vaccinations?		

Informed Consent

- I agree to remain at the location for 15 minutes or for the duration specified/directed by the Pharmacist.
- I understand that there are possible adverse effects associated with administration of the below mentioned vaccine.
- I understand that I may, at any time before, during or after the injection, ask the pharmacist further questions.
- In the event of an emergency, I authorize the Pharmacist to administer epinephrine and/or perform any necessary lifesaving procedures until medical support arrives. In the case of an emergency, please contact:

Emergency Contact: _____ **Phone#:** _____

- I understands that I may experience symptoms following influenza immunization *(i.e. Cough, Fever, etc)* that are similar to symptoms that present with COVID-19 infection and am aware to contact my public health line if symptoms occur.
- I understand that the Pharmacist will comply with all professional standards for administering injections. I acknowledge that the Pharmacist has discussed the risks and benefits of receiving this injection with me and has answered my questions.

Patient Signature (Guardian): _____ **Date:** _____

FOR PHARMACIST USE ONLY

VACCINE INFORMATION:			**PHARMACY INFORMATION:**	
Vaccine Name:			**Pharmacist Signature:**	
Dose (ml):			**License#:**	
Lot#:			**Date of Administration:**	
Expiry Date:			**Time of Administration:**	
Vaccination Site:	☐ **Left Arm**	☐ **Right Arm**	**Route:**	☐ **Intramuscular**

INJECTION ASSESSMENT

Pre: _____

During: _____

Post: _____

Adverse Reaction? ☐ **No** ☐ **Yes**

If so, describe reaction: _____

_____

Pharmacy Label