

## Section 1: Personal Information

Patient First and Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No:	
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age:	Child's Weight: kg or lb
			Date of Birth (MM/DD/YYYY)
Name of Emergency Contact:		Contact's Daytime Phone Number:	
Emergency Contact's Relationship to Patient:		Contact's Evening/Other Phone Number:	

## Section 2: Screening Questionnaire

**For adult patients as well as parents of children (≥ 5 years of age) to be vaccinated:**

The following questions will help us determine if there is any reason you or your child should not get the flu shot today. If you answer "yes" to any question, it does not necessarily mean the shot cannot be given. It simply means additional questions must be asked.

If a question is not clear, please ask your pharmacist to explain it.

Please answer the following questions	Yes	No	Unsure	Action required
Are you <b>sick today</b> ? (fever greater than 39.5°C, breathing problems, or active infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do <u>NOT</u> get the shot today
Are you <b>allergic</b> to any medications including vaccines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , list what you are allergic to here:
Are you <b>allergic</b> to any of the following? Check all that apply:  <input type="checkbox"/> Thimerosal <input type="checkbox"/> Egg protein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , your pharmacist can check whether the flu shot contains any of these potential allergens and use one which does not.
Are you <b>allergic</b> to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> or <u>UNSURE</u> , do <u>NOT</u> get the shot & <u>SPEAK WITH YOUR MD</u>
Have you had <b>wheezing, chest tightness or difficulty breathing</b> within 24 hours of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a reaction to <b>eggs or egg products</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> or <u>UNSURE</u> , speak to the pharmacist, you may be able to receive the flu shot but <u>may require a longer observation period post-administration.</u>
Do you have any <b>serious allergy</b> to latex or natural rubber?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> or <u>UNSURE</u> , you can receive the flu shot but non-latex materials are to be used
Have you had <b>Guillain-Barré Syndrome</b> within 6 weeks of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do not get the flu shot and <u>SPEAK WITH YOUR MD</u>
Do you have a <b>new or changing</b> neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do not get the flu shot & <u>SPEAK WITH YOUR MD</u>
Do you have <b>bleeding problems or use blood thinners</b> ? (e.g. warfarin, low dose or regular strength aspirin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , shot can be given but apply gentle pressure afterwards

Seasonal Influenza Vaccine  
Consent Form and Rx Template 2020-21

**Section 3: Consent Given By Patient/Agent**

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the [Flu Shot Fact Sheet](#). I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the flu shot. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu shot.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips.

In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

I confirm that I want to receive the seasonal influenza vaccine **OR**  I confirm that I want my child to receive the seasonal influenza vaccine

<b>Patient/Agent Name (&amp; Relationship)</b>	<b>Patient/Agent Signature</b>	<b>Date Signed (MM/DD/YYYY)</b>
<b>PHARMACIST DECLARATION:</b> I confirm the above named patient/agent is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient.		
<b>Pharmacist Signature</b>	<b>OCP License #</b>	<b>Date Signed (MM/DD/YYYY)</b>

**Section 4: Prescription Templates – Pharmacy Use Only**

INFLUENZA VACCINE			EPINEPHRINE EMERGENCY TREATMENT	
Patient Name:			Patient Name:	
<input type="checkbox"/> FLULAVAL TETRA – DIN 02420783 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial			<input type="checkbox"/> EpiPen® DIN 00509558 – <b>Note: Use the PIN 09857423 for EpiPen claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02432730 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial			<input type="checkbox"/> EpiPen Junior® DIN 00578657 – <b>Note: Use the PIN 09857424 for all EpiPen Junior claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02420643 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe			<input type="checkbox"/> Allerject® 0.3 mg/0.3 mL DIN 02382067 – <b>Note: Use the PIN 09857440 for Allerject 0.3 mg/0.3 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUCELVAX® QUAD – DIN 02494248 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe			<input type="checkbox"/> Allerject® 0.15 mg/0.15 mL DIN 02382059 – <b>Note: Use the PIN 09857439 for Allerject 0.15 mg/0.15 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUZONE® HIGH-DOSE – DIN 02445646 – HD-TIV 60 mcg/0.5 mL – 0.5 mL (single-dose) syringe			<input type="checkbox"/> Emerade™ 0.5 mg/0.5 mL DIN 02458454 – <b>Note: Use the PIN 09858130 for Emerade 0.5 mg/0.5 mL claims for adverse events within the UIIP</b>	
			<input type="checkbox"/> Emerade™ 0.3 mg/0.3 mL DIN 02458446 – <b>Note: Use the PIN 09858129 for Emerade 0.3 mg/0.3 mL claims for adverse events within the UIIP</b>	
Vaccine Lot #:	Expiry (MM/YYYY):		Number of Doses Administered:	
Date of Immunization:	Time of Immunization:		Date of Administration:	Time(s) of Administration: 1. 2. (if applicable) 3. (if applicable)
Dose	Route <b>IM</b>	Site of administration <input type="checkbox"/> Left: _____ <input type="checkbox"/> Right:	Administering Pharmacist Name and OCP #:	Administering Pharmacist Signature:
Administering Pharmacist Name and OCP #:			Additional Notes (including other emergency measures taken or treatments administered):	
Administering Pharmacist Signature:			Date & Time of Follow-up with Patient/Agent:	

## 2020 -2021 Influenza Vaccination: COVID Screening and Consent

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand the novel coronavirus causes the disease known as COVID-19. I understand that COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

**I accept and acknowledge that I could be exposed to COVID-19 through the following means (this list is not exhaustive):**

- My interactions with other patients or members of the public who are present at the pharmacy at the time of my attendance;
- My interactions with pharmacy staff, agents and other health care professionals at the pharmacy;
- The physical touching of any equipment or fixtures in the pharmacy.

While receiving my vaccination(s) or other pharmacy services, the Service Provider (pharmacist or other pharmacy staff) may need to be physically closer to me than the recommended social distancing guidelines in order to assess, vaccinate, and/or treat me. \_\_\_\_\_ (Initial)

**Prior to attending the pharmacy for my vaccination(s), or other pharmacy services, I confirm that:**

- I do not have: a fever > 38°C, Cough, Sore Throat, or Flu-like Symptoms;
- I am not currently positive for COVID-19;
- I am not currently waiting on results from a COVID-19 laboratory test;
- I have not been in contact with any person(s) who have, or are suspected to have COVID-19, or are awaiting results on a COVID-19 laboratory test in the past 14 days;
- I have not returned to Ontario from any country outside of Canada in the past 14 days.

\_\_\_\_\_  
**Signature of Patient (or Guardian)**

\_\_\_\_\_  
**Date**

I acknowledge that I have read and fully understand the risks as described above. I acknowledge and confirm that I am willing to accept these risks as a condition of attending the pharmacy to receive the Services from the Service Provider.