

2024 – 2025 Seasonal Influenza (Flu) +/- COVID Vaccine Consent Form

Section 1: Patient Information

Last Name:	First Name:	HealthCard No.:	Gender:	Age:
Phone No.:	Date of Birth (DD/MMM/YYYY):	Emergency Contact Name & Phone No.:		
Address:	City:	Province:	Postal Code:	
Usual / Home Pharmacy:		Primary Care Provider (Family MD, NP):		

Section 2: Screening Questionnaire

In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing, runny nose, feeling unwell?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a reaction to any immunization previously (e.g. hives, fainting, difficulty breathing)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have allergies to medications, food (e.g. eggs), vaccine components, or latex? List:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take any medications that suppress your immune system or are you immunocompromised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take any medications (e.g. blood thinner) that can affect blood clotting or have a bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of Oculo-Respiratory Syndrome ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of Guillain-Barré Syndrome within 6 weeks of any vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any new or changing neurological conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant, nursing , or do you intend to become pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever suffered from inflammation of the heart or lining of the heart (myocarditis/pericarditis) after a previous dose of a COVID-19 vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a COVID-19 infection ? If yes, please indicate when it was resolved :	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received a previous dose of COVID-19 vaccine ? If yes, please specify most recent brand :	& date:

Section 3: Consent Given By Patient/Agent

I, the client, parent or guardian, have read or had explained to me information about the vaccine(s). I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the vaccine(s). I agree to wait in the pharmacy for 15 minutes (or longer, if recommended by a Healthcare Provider) after receiving the vaccine(s).

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine(s). Some serious reactions called "anaphylaxis" can be life-threatening and are deemed medical emergencies. 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 911 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include but is not limited to hives, difficulty breathing, and/or 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 were received, or a copy will be provided to my agent or EMS paramedics.

I confirm that I want to receive the vaccine(s) **OR** I confirm that I want my child to receive the vaccine(s)

Patient/ Agent Name (& Relationship)	Patient / Agent Signature	Date Signed (DD/MMM/YYYY)
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PHARMACY USE ONLY Section 4: Vaccine Documentation

<input type="checkbox"/> FLULAVAL® TETRA - QIV DIN: 02420783 15 mcg/ 0.5 mL (5 mL multi-dose vial) Age 2+	<input type="checkbox"/> FLUZONE® QUADRIVALENT DIN: 02432730 15 mcg/ 0.5 mL (5 mL (multi-dose vial) Age 2+	<input type="checkbox"/> FLUZONE® QUADRIVALENT DIN: 02420643 15 mcg/ 0.5 mL (0.5 mL single-dose syringe) Age 2+	<input type="checkbox"/> COVID - Pfizer KP.2 0.3mL IM (DIN: 02541823) (Age 12+)		
<input type="checkbox"/> FLUZONE® HIGH-DOSE - QIV DIN: 02500523 60 mcg/ 0.7 mL (0.7 mL single-dose syringe) Age 65+	<input type="checkbox"/> FLUAD® TIV - Adjuvanted DIN: 02362384 15 mcg/ 0.5 mL (0.5 mL single-dose syringe) Age 65+	<input type="checkbox"/> FLUCELVAX® QUAD DIN: 02494248 15 mcg/ 0.5 mL (0.5 mL single- dose syringe) Age 2+	<input type="checkbox"/> COVID - Other: Dose (IM) : DIN:		
Flu Vaccine	Lot No.:	Expiry: MM/YYYY	Site of Administration: <input type="checkbox"/> LEFT Deltoid <input type="checkbox"/> RIGHT Deltoid	Time of Immunization:	Date of Immunization (DD/MMM/YYYY)
COVID - KP.2	Lot No.:	Expiry: MM/YYYY	Site of Administration: <input type="checkbox"/> LEFT Deltoid <input type="checkbox"/> RIGHT Deltoid	Time of Immunization:	
HealthCare Provider's Name & License No.:			HealthCare Provider's Signature:		

Adverse Reaction: Yes No Emergency Treatment Administered: Name/ DIN: Lot: Exp: Response: