INJECTION CONSENT FORM (Ask your pharmacist about age restriction for flu shots in a pharmacy)

Section 1: Patient Information

Last Name:	First Name	Health Card #		Gender
Phone Number:	Alternate number:	Date of Birth:	Age:	Child's Weight (kg/lb):
Address:		City:	Province:	Pstal Code:
Emergency Contact's Last Name:	Emergency Contact's First Name:			Relationship:
Emergency Contact's Phone #	Emergency Contact's Alternate Phone #:			

Section 2: Screening Questionnaire

	YES	NO
Are you, or have you been sick today, or within the past 3 days? (fever greater than 39.5°C, breathing problems, or active infection)		
Have you had difficulty breathing, wheezing or chest tightness within 24 hours of getting a vaccine?		
Are you allergic to any part of the influenza vaccine, or have you had a severe, life-threatening allergic reaction to a past influenza vaccine?		
Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to: • Contact lens solution • Egg or egg products • Formaldehyde • Gelatin • Gentamicin •		
Do you have a serious allergy to latex or natural rubber?		
Have you had a reaction to eggs or egg products but can still eat small amounts of egg? (eg. Stomach ache, skin reaction)		
Have you had Guillian-Barré Syndrome within 6 weeks of getting an influenza vaccine? Oculo-Respiratory Syndrome?		
Have you ever had a seizure or have an active, new, or changing brain/nervous system/neurological disorder?		
Do you have bleeding problems or use blood thinners? (eg. Warfarin)		
Are you pregnant, nursing, or do you intend to become pregnant?		
Have you received your pneumonia vaccines? If yes, which vaccine and when: _		
Have you received your shingles vaccines? If yes, which vaccine and when:		
Have you received any vaccines in the last 4 weeks? If yes, please list.		
For children under 18 years old: Is the child using, or will be using an aspirin/aspirin-containing therapy in the next 4 weeks?		
Do you have severe asthma (on high dose inhaled or oral corticosteroids) or medically attended wheezing in the past 7 days?		
Have you received in the past 48 hours or do you intend to receive in the next 2 weeks flu antiviral therapy? (eg. Oseltamivir)?		
Do you have any medical conditions (eg. Cancer, leukemia, HIV/AIDS) or take medications that weaken the immune system?		
Do you provide health care services to or do you have close contact with persons who are immunocompromised?		
Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to Arginine?		

Section 3: Consent Given By Patient/Agent

I, the undersigned patient, parent or guardian, have read or have had explained to me information about the seasonal influenza vaccine ("Vaccine") as outlined on the Flu Vaccine 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 Vaccine. After getting the Vaccine, I agree to wait in the clinic/pharmacy for 15 minutes (or the time recommended by thepharmacist). I am aware it is possible (yet rare) to have an extreme allergic reaction to any component of the Vaccine. Serious reactions called "anaphylaxis" can be life- threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following vaccination, I am aware it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to treat this reaction and 9-1-1 will be called to provide additional assistance. In the event of anaphylaxis, I, my agent, and/or EMS paramedics will receive a copy of this form. I understand the information contained on this form, may be disclosed to the public health authority and to other required parties for the purpose of adverse event and drug safety

☐ I confirm that I/my child want to receive the vaccine/injection

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date Signed (MM/DD/YYYY)

PHARMACY USE ONLY Section 4: Prescription Templates Vaccine Used

HEALTH CARE PROVIDER'S DECLARATION: ☐ I confirm the above named patient is capable of providing consent for the seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient. I am administering the seasonal influenza vaccine no more than 21 days after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient

Trivalent Flu Vacc	☐ **VAXIGRIP®** IM 0.5mL DIN02367718	☐**AGRIFLU®** IM 0.5ml DIN02346850	☐**INFLUVAC** IM 0.5ml DIN02269562	☐**FLUVIRAL®** 0.5ml IM DIN02420686	☐ **FLUZONE High-Dose** IM 0.5mL DIN02445646	☐ **FLUAD®**IM 0.5 mL DIN02362384	☐**INFLUVAC®** IM 0.5 mL DIN02269562
Tetravalent FLU Vaccine	**AFLURIA® TETRA** ☐ 0.5mL IM pre-filled syringe DIN02473283 ☐ 5mL IM multi-dose vial DIN02473313	**FLUCELVAX® QUAD IM** ☐ 0.5mL pre-filled syringe DIN02494248 ☐ 5mL multi-dose vial DIN02494348		**FLUZONE® QUAD** IM ☐ 0.5mL single-dose vial DIN02420643 ☐ 5mL multi-dose vial DIN02432730	☐ **INFLUVAC TETRA** 0.5mL IM DIN02484854	☐ **FLULAVAL TETRA** 0.5mL IM DIN02420783	
Other Injections	☐ **SHINGRIX®** IM 0.5ml DIN 02468425 DOSE(**1**) DOSE(**2**)	☐ **PREVNAR®** IM 0.5mL DIN02335204	☐ **TRUMENBA®** IM 0.5mL DIN02468751	☐ **NIMENRIX®** IM 0.5mL DIN02402904	☐ **PROLIA® SC** 0.5mL DIN02335204	☐ **Vit B12 IM** ----mls DIN00521515	☐ **Allergy Shots**

Date of Shot	**Time** of Shot	**Lot #:**	**Expiry:**	Pharmacist Name & License#	Signature

Arm Admin site☐Left☐Right	Contacted Primary Prescriber: ☐yes ☐No, Patient to inform his doctor.	Emergency treatment: ☐Yes ☐No