RxPharmaChoice

CONSENT FOR INFLUENZA VACCINE ADMINISTRATION

Patient Name: _____ **Gender:** _____

Personal Health# (PHN): _____ **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 ever had a reaction to a vaccine in the past? Any Allergic Reactions or Guillain-Barre Syndrome?	☐	☐
8. **Female Patients**: Are you pregnant, trying to conceive or breastfeeding?	☐	☐

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**

Adverse Reaction: ☐ **No** ☐ **Yes**

Describe Reaction: _____

_____

_____

Pharmacy Label