Seasonal Influenza (Flu) VaccineScreening and Consent Form 2021-2022

Rob's wholehealth pharmacy

Section 1: Patient Information

Name (First & Last):	Health Card (OHIP) Number:	
Preferred Name:	Date of Birth:	Weight (if under 18 years old):
Gender Identity:	Gender Associated with your Health Card (for billing purposes): ☐ M ☐ F ☐ X	
Address:	Telephone:	
	Emergency Contact (Name, Phone Number, Relationship):	

Section 2: COVID-19Screening Questionnaire

Question	Yes	No	Unsure	Question	Yes	No	Unsure
Have you been fully vaccinated against COVID-19?				In the **past 14 days**, have you experienced any COVID-19 symptoms?			
Have you tested **positive** for COVID-19 and have **not been cleared**?				In the **past 14 days**, did you return from **travel outside of Canada and been told to quarantine**?			
Do you have **any symptoms** of COVID-19 today? (fever, cough, shortness of breath, breathing difficulty, sore throat, difficulty swallowing, decrease or loss of sense of taste or smell, chills, headaches, unexplained fatigue/malaise/muscle aches, nausea/vomiting, diarrhea, abdominal pain, pink eye, runny nose or nasal congestion without other known cause)				Are you **living with**, or have you been identified as a **"close contact"** of an individual who: currently has COVID-19 OR is awaiting COVID-19 test results after **experiencing symptoms**?			
				In the last 10 days, have you received a **COVID Alert exposure** notification on your cell phone?			
				Has a doctor, healthcare provider or public health unit told you that you should **currently be under self-isolation** (quarantine)?			

Section 3: Influenza Screening Questionnaire

Question	Yes	No	Unsure	Question	Yes	No	Unsure
Are you **sicktoday**? (fever > 39.5°C, breathingproblems, active infection)				Are you **allergic** to any medications including vaccines?			
Are you **allergic** to any of the following? Contact lens solution, gelatin formaldehyde, neomycin, kanamycin, gentamycin, thimerosal				Are you **allergic** to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flushot?			
Have you had **wheezing**, **chesttightness** or **difficultybreathing** within 24 hours of getting a flu shot?				Have you had a severe reaction to **eggs** or **eggproducts**? (e.g. wheezing, chest tightness, difficultybreathing, hives)			
Are you or do you think you might be **pregnant**?				Do you have a **new** or **changing** neurological disorder?)			
Have you had **Guillain Barré Syndrome** within 6 weeks of getting a flu shot?				Do you have **bleedingproblems** or use **bloodthinners**? (e.g. warfarin, aspirin)			

Section 4: Immunization Screening Questionnaire (Optional)

Question	Yes	No	Unsure	Question	Yes	No	Unsure
For individuals **over 50 years old,** have you received a **pneumonia** vaccine?				For individuals **10-25 years old**, have you received a **meningitis B** vaccine?			
For individuals **over 50 years old,** have you received **shingles** vaccines?				If you answered "No" or "Unsure" to any of the last three questions, may the pharmacist discuss these recommended vaccines for your age group with you?			

Section 5: Patient Information

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on this screening and consent form. 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 911 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 <u>my child</u> to receive the seasonal influenza vaccine**

Patient/Agent Name (& Relationship):	Patient/Agent Signature:	Date Signed:

Section 6: Pharmacy Use Only

Vaccine Lot:	**QIV Vaccine administered:**	**TIV-adj orQIV-High Dose vaccine administered:**
Expiry (MM/YYYY):	**FLUZONE Quadrivalent**(0.5 mL)(*2+ years*) ☐DIN: 02420643 Pre-filled syringe ☐DIN: 02432730 Multi-dose vial **FLULAVAL Tetra**(0.5 mL)(*2+ years*) ☐ DIN: 02420783Multi-dose vial **FLUCELVAXQuad**(0.5 mL) (*2+ years*) ☐ DIN: 02494248Pre-filled syringe **AFLURIATetra** (0.5 mL)(*5+ years*) ☐ DIN: 02473283 Pre-filled syringe ☐ DIN: 02473313 Multi-dose vial **OTHER:** ☐DIN:	**FLUZONE High-Dose Quadrivalent** (0.7mL)(*65+ years*) ☐DIN: 02500523 Pre-filled syringe
Date of Immunization:		
Time of Immunization:		**FLUAD TIV-adjuvanted** (0.5mL)(*65+ years*) ☐DIN: 02362384 Pre-filled syringe
☐ Left arm *OR*☐ Right arm		

<u>PHARMACIST DECLARATION:</u>
I confirm the above-named patient is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient.

Pharmacist:	License #:	Signature:	Date Signed:

Section 7: Epinephrine Emergency Use Only (Recommended Dose= 0.01mg/kg; MAX 0.5mg per dose)*

Patient's Last Name:	Patient's First Name:	Patient's Date of Birth (MM/DD/YYYY)
Epinephrine 0.15 mg* Children (age 2-7): Weight: 11 to 20kg (24-45lbs) ☐ **EpiPen Junior** DIN 00578657 PIN 09857424 ☐ **Allerject** DIN 002382059 PIN 09857439 **Note: Weightis the preferred basis for dosage; use age if weight is unknown**	**Epinephrine 0.3 mg*** Children (age 7-12): Weight:21 to 45kg (46 – 100 lbs) ☐ **EpiPen Adult** DIN 00509558 PIN 09857423 ☐ **Allerject** DIN 002382067 PIN 09857440 ☐ **Emerade** DIN002458446 PIN 09858129	**Epinephrine 0.5 mg*** Adolescents (age 12+) and adults: Weight≥46kg (≥101 lbs) ☐ **Emerade** DIN 002458454 PIN 09858130

Date of Administration (MM/DD/YYYY)	Times of Epinephrine Administration 1. 2. (if needed) 3. (if needed)
Number of Doses Administered:	
Pharmacist's Name and License #:	Pharmacist Signature:
Additional Notes (any emergency measures taken, or treatments administered):	Follow-up Date (MM/DD/YYYY): Follow-up Time:

*Recommended doses from Canadian Immunization Guide https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-2-vaccine-safety/page-4-early-vaccine-reactions-including-anaphylaxis.html#t4