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 had a reaction to a vaccine in the past? Allergic Reactions or Guillain-Barre Syndrome		
8. Are you pregnant, trying to conceive or breastfeeding?		
9. Have you had a mastectomy? If yes, ☐ Left ☐ Right		

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 understand 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

INJECTION ASSESSMENT

Pre: ____________________________

During: __________________________

Post:____________________________

Adverse Reaction? ☐ **No** ☐ **Yes**

If so, describe reaction:____________________

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Pharmacy Label