

Section 1: Personal Information

Patient First & Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No:	
Male	Female	Age:	Child's Weight: kg or lb
			Date of Birth (MM/DD/YYYY)
Name of Emergency Contact:		Contact's Daytime Phone Number:	
Emergency Contact's Relationship to Patient:		Contact's Evening/Other Phone Number:	

Section 2: Screening Questionnaire

For adult patients as well as parents of children (≥ 5 years of age) to be vaccinated:

The following questions will help us determine if there is any reason you or your child should not get the flu shot today. If you answer “yes” to any question, it does not necessarily mean the shot cannot be given. It simply means additional questions must be asked.

If a question is not clear, please ask your pharmacist to explain it.

Please answer the following questions	Yes	No	Unsure	Action required
Are you sick today ? (fever greater than 39.5°C, breathing problems, or active infection)				If <u>YES</u> , do <u>NOT</u> get the shot today
Are you allergic to any medications including vaccines?				If <u>YES</u> , list what you are allergic to here:
Are you allergic to any of the following? Check all that apply: Neomycin Thimerosal Egg protein Polymyxin B				If <u>YES</u> , your pharmacist can check whether the flu shot contains any of these potential allergens and use one which does not.
Are you allergic to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?				
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a flu shot?				If <u>YES</u> or <u>UNSURE</u> , do <u>NOT</u> get the shot & <u>SPEAK WITH YOUR MD</u>
Have you had a severe reaction to eggs or egg products ? (e.g. wheezing, chest tightness, difficulty breathing, hives)				
Have you had a reaction to eggs or egg products but can still eat small amounts of egg? (e.g. stomachache)				If <u>YES</u> or <u>UNSURE</u> , you can receive the flu shot but <u>MUST BE OBSERVED FOR 30 MINUTES AFTERWARDS</u>
Do you have any serious allergy to latex or natural rubber?				If <u>YES</u> or <u>UNSURE</u> , you can receive the flu shot but non-latex materials are to be used
Have you had Guillain-Barré Syndrome within 6 weeks of getting a flu shot?				If <u>YES</u> , do not get the flu shot and <u>SEE YOUR MD</u>
Do you have a new or changing neurological disorder?				If <u>YES</u> , do not get the flu shot & <u>SEE YOUR MD</u>
Do you have bleeding problems or use blood thinners ? (e.g. warfarin, low dose or regular strength aspirin)				If <u>YES</u> , shot can be given but apply gentle pressure afterwards

Screening Questionnaire for Inactivated Injectable Influenza Vaccine 2019–20

Consent Form & Rx Template 2019–20

Section 3: Consent Given By Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the Flu Shot 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 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 9-1-1 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 my child to receive the seasonal influenza vaccine

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date Signed (MM/DD/YYYY)
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PHARMACIST DECLARATION: I confirm the above named patient/agent is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient.

Pharmacist Signature	OCP License #	Date Signed (MM/DD/YYYY)
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Section 4: Prescription Templates – Pharmacy Use Only

INFLUENZA VACCINE			EPINEPHRINE EMERGENCY TREATMENT	
Patient Name:			Patient Name:	
FLULAVAL TETRA – DIN 02420783 – QIV 15 mcg/0.5mL – 5 mL (multi-dose) vial			EpiPen® DIN 00509558 – Note: Use the PIN 09857423 for EpiPen claims for adverse events within the UIIP	
FLUZONE® QUADRIVALENT – DIN 02432730 – QIV 15 mcg/0.5mL – 5 mL (multi-dose) vial				
FLUZONE® QUADRIVALENT – DIN 02420643 – QIV 15 mcg/0.5mL – 0.5 mL (single-dose) syringe			EpiPen Junior® DIN 00578657 – Note: Use the PIN 09857424 for all EpiPen Junior claims for adverse events within the UIIP	
AFLURIA® TETRA – DIN 02473283 – QIV 15 mcg/0.5mL – 0.5 mL (single-dose) syringe				
Vaccine Lot #:	Expiry (MM/YYYY):		Number of Doses Administered:	
Date of Immunization:	Time of Immunization:		Date of Administration:	Time(s) of Administration: 1. 2. <i>(if applicable)</i> 3. <i>(if applicable)</i>
Dose	Route IM	Site of administration Left: Right:	Administering Pharmacist Name and OCP #:	Administering Pharmacist Signature:
Administering Pharmacist Name and OCP #:			Additional Notes (including other emergency measures taken or treatments administered):	
Administering Pharmacist Signature:			Date & Time of Follow-up with Patient/Agent:	