MEDICATION / VACCINE ADMINSTRATION SCREENING AND CONSENT FORM

Please complete this form and read the supplemental information provided by the pharmacist before receiving ____________________ (name of medication / vaccine). Your answers to these questions will help the Pharmacist determine if there is any reason why you should not receive this medication / vaccination at this time. If you are a parent or guardian providing consent for a child or other person, please complete this information for the person who will be receiving the medication / vaccination.

Patient Information

First Name:	Last Name:	
Date of Birth: (MM/dd/yyyy)	Age:	Gender: M F NOS
Address: Street: Apartment City Province Postal		
Health Card #:	Telephone:	
Emergency Contact Name and Telephone number		

Screening Questionnaire for Person Receiving Medication / Vaccination	YES	NO
Are you sick today (I.e. fever greater than 39.5°C, breathing problems, active infection?		
Do you have an allergy to food, medication, vaccine, or latex?		
Do you take a blood thinner or have a bleeding disorder?		
Have you had a serious reaction to a medication or vaccine in the past?		
Do you have a new or changing condition affecting the brain or nervous system?		
Have you ever had Guillain-Barré syndrome?		
For Live Vaccines Only:		
Are you pregnant, planning to become pregnant or breastfeeding?		
Do you have a long-term medical condition such as asthma, diabetes, lung disease, heart disease or kidney disease?		
Have you received a blood transfusion, blood product, immune globulin or antiviral drug in the past year?		
Do you have a medical condition or are you taking medication that affects your immune system (I.e. cancer, HIV, taking prednisone or other corticosteroids?)		
Have you received any vaccines in the past 4 weeks?		
Are you under 18 years of age and taking medication containing ASA?		

Patient / Agent Consent for Medication / Vaccine Administration

I consent to having the pharmacist administer ________________________ (name of medication / vaccine), __________________________ (dose and route of medication / vaccine). I have reviewed the information about this medication / vaccine and procedure provided to me and the pharmacist has answered my questions. I understand the risks, benefits, expected outcome and possible side effects of this medication / vaccine and agree to wait in the pharmacy for ______ minutes after receiving the medication / vaccination. I agree to see a doctor if I develop any side effects or health problems after receiving the medication / vaccination. I agree that the pharmacy may share my personal health information regarding this medication / vaccination as required with public health officials and other health care providers.

I am providing Consent for myself	I am providing consent for the patient named above.	
If providing consent for patient above, please complete the following:		
Contact information of patient agent:	*Name*	*Telephone*
Relationship to the Person: Parent Guardian Other ___________________________		
Name of person Providing Consent:	Signature	Date

Pharmacy Use Only Pharmacist Documentation		
Medication / vaccine product given: Manufacturer:		Date of Administration: (mm/dd/yyyy)
Lot number:		Time of Administration: _______________ AM/PM
Expiry Date (mm/dd/yyyy):		
Medication total Dose administered: 0.5 mL 1 mL 1.5 mL		Route and site of administration: IM SC Deltoid: Right Left Other:
Rationale for medication / vaccination administered	Prevention of disease: (specify)	
Patient counselling	Potential adverse reactions and their management Other:	
Patient Response	Before med/vaccine admin: During med / vaccine admin: Immediately after med / vaccine admin: After waiting period	
Adverse Reactions	Did the patient have an adverse reaction? Yes No If Yes describe the nature of the reaction and action taken:	
Communication	Public Health Healthcare Provider Name: Method of notification: Fax Phone Other Date of notification Comments (optional)	
Follow-Up	Yes No (*if yes describe the reason for follow-up and timing)* Date: Reason:	
I confirm that the patient named in this document is capable of providing consent to receive the medication / vaccine indicated in this document or that the a parent / guardian or other agent has provided consent on behalf of the patient. I confirm that the medication / vaccine should be given to the patient based on my assessment.		
Name and title of pharmacist administering Medication / vaccine:		
Pharmacist License Number:		Signature: