SEASONAL INACTIVATED INFLUENZA VACCINATION SCREENING AND CONSENT FORM

Please complete this form and read the section entitled "Preparing for the fu shot" before receiving the seasonal inactivated influenza vaccine ("flu-shot"). Your answers to these questions will help the pharmacist determine if there is any reason why you should not receive this vaccine. If you are a parent or guardian providing consent for a child or other person, please complete this form for the person being vaccinated.

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 to be Vaccinated	YES	NO
Are you sick today (I.e. fever greater than 39.5°C, breathing problems, active infection?		
Have you had a serious reaction to influenza vaccine in the past?		
Do you have any allergies, including allergy to eggs or egg products?		
Do you have an allergy to any component of the flu vaccine? (gentamicin, neomycin, kanamycin, thimerosal, formaldehyde)		
Do you take a blood thinner or have a bleeding disorder?		
Do you have a new or changing condition affecting the brain or nervous system?		
Have you ever had Guillain-Barré syndrome?		
Are you pregnant?		
If patient is a child less than 9 years old, are they receiving the Influenza vaccine for the first time?		
If you are 50 years or older, have you received a Shingles vaccine in the past?		
If you are 50 years or older, have you received the Pneumococcal vaccine in the past?		

Patient / Agent Consent for Medication / Vaccine Administration

I consent to having the pharmacist administer the seasonal inactivated flu vaccine. I have reviewed the document entitled "Preparing for the Flu Shot" and the pharmacist has answered my questions. I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the pharmacy for 15-30 minutes. I agree to see a doctor if I develop any side effects or health problems after receiving the vaccine. 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 consent to be contacted by telephone by this Pharmacy, or an authorized agent thereof, regarding this vaccination and other related services that may benefit me.

☐ 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

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Preparing for the Flu Shot

What is influenza? Influenza ("the flu") is an infection of the respiratory tract that is caused by a virus. It is spread through coughing, sneezing, shaking hands or by touching contaminated objects. Symptoms include sudden high fever, cough, headache, muscle aches, loss of appetite and fatigue. Flu season in Canada usually lasts from November to April.

Why get the Flu Shot? It can not only prevent you from becoming ill, but also from spreading influenza to those who may be at risk of more serious complications, such as pneumonia. Getting a flu shot every year is an important part of your defense against influenza because the type of virus changes from year to year.

Who should get it, and who should not get it? It is recommended that everyone aged 6 months of age and older get the flu shot. You should speak with your pharmacist or doctor first if you have a history of a severe allergic reaction to influenza vaccine. Or a component of the vaccine, or a history of Guillain-Barré syndrome because the flu shot may ***not*** be appropriate for you. If you are ill with a fever, the pharmacist may ask you to come back for your flu shot when you are better. Inform the pharmacist if you have a severe egg allergy or any other allergies.

What can I expect from the Flu Shot? The injection is usually given in the arm so the pharmacist will require access to your upper arm. The flu shot does not cause the flu. The most common side effect is soreness at the site of the injection. Some people can also develop a fever and muscle aches. The pharmacist will ask you to wait at the pharmacy for approximately 15 minutes after your injection to make sure that you do not have a reaction to the vaccine.

What should I do if I experience a side effect or reaction from the flu shot? For soreness, ask the pharmacist if an over-the-counter pain medication may be appropriate for you, or apply a cold cloth to the area. If you experience a less common reaction such as red eyes, breathing problems, and swelling of th efface (called oculorespiratory syndrome) see your doctor if these symptoms do not go away. Guillain-Barré syndrome is rare and causes symptoms such as muscle weakness, tingling, and numbness in the legs and feet or loss of movement. If you are concerned about your symptoms, see your doctor.

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☐ Flulaval (GSK) DIN:	☐ Agriflu (Seqirus) DIN	☐ Vaxigrp (Sanofi Pasteur) DIN	☐ Fluad (Seqirus) DIN	☐ Fluviral (GSK) DIN	☐ Fluzone QIV (Sanofi Pasteur) DIN	☐ Influvac (Mylan-BGPPharma) DIN	☐ Other Manufacturer: DIN:

Route of administration: IM ☐	Date of Administration: (mm/dd/yyyy)
Lot number: / Expiry Date (mm/dd/yyyy):	Time of Administration: _____ AM/PM
Medication total Dose administered: ☐ 0.5 mL	Site: Deltoid ☐ Left ☐ Right

Rationale for vaccination	☐ Prevention of influenza, no contraindications.
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 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: