Seasonal Influenza (Flu) Vaccine Screening & Consent Form 2021-2022

Section 1: Patient Information

Hauser's PHARMACY

Name (First & Last):		Health Card (OHIP) Number:
Date of Birth: (YYYY/DD/MM)	Gender Associated with Healthcard: (billing purposes) ☐Male ☐Female ☐X	Email: Phone:
Mailing Address:		
Emergency Contact: (Name, Phone Number, Relationship)		

Section 2: Influenza Screening Questionaire

Questions	Yes	No	Unsure	Covid-19 Questions	Yes	No	Unsure
Are you or do you think you might be pregnant?				Are you sick today? (fever >39.5°C, breathing problems, active infection)			
Have you had Guillain Barré Syndrome within 6 weeks of getting a flu shot?				Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a flu shot?			
Are you allergic to any of the following? Contact lens solution, gelatin formaldehyde, neomycin, kanamycin, gentamycin, thimerosal				Have you travelled outside of the province within the last 14 days?			
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 experienced any of the following in the last 48 hours: Fever and/or chills, new onset cough or worsening cough, shortness of breath?			
Have you had a severe reaction to eggs or egg products? (e.g. wheezing, chest tightness, difficulty breathing, hives)				Have you experienced any of the following in the last 48 hours: Decrease or loss of smell or taste, fatique, lethargy, maliase and/or muscle aches? (Adults >18)			
Are you allergic to any medications including vaccines?				Have you experienced any of the following in the last 48 hours: nausea, vomitting and/or diarrhea (children <18)			
Do you have a new or changing neurological disorder?				Have you tested positive for covid-19 in the last 10 days?			
Do you have bleeding problems or use blood thinners? (e.g. warfarin, aspirin)				Have you been in close contact with a confirmed case of COVID-19 without wearing appropriate PPE?			

Section 3: 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 recieve the seasonal influenza vaccine. **OR** ☐I Confirm that I want my child to recieve the seasonal influenza vaccine.

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

Section 4: PHARMACY USE ONLY

Vaccine Lot:	**Vaccine adminstered today (please circle):**					
Expiry: (MM/YYYY) Date of Immunization:	**FLUZONE** QIV (0.5ml) - Vial (DIN: 2432730)	**FLUZONE HD QIV** (0.5ml) -Prefilled syringe (DIN: 02500523)	**FLULAVAL** QIV(0.5ml) - Vial (DIN: 2420783)	**FLUCELVAX QUAD** QIV (0.5ml) - Vial (DIN: 2420783)	**FLUAD** TIV (0.5ml) - Prefilled Syringe (DIN: 02362384)	**AFLURIA TETRA** QIV (0.5ml) - Prefilled syringe (DIN: 02473283)
Time of Immunization:	Left arm OR Right arm					
Date & Time of Follow-up with Patient/Agent:						

Pharmacist Declaration:
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: