2024 – 2025 Seasonal Influenza (Flu) +/- COVID Vaccine Consent Form

Section 1: Patient Information

Last Name:	First Name:	HealthCard No.:	Gender:	Age:
Phone No.:	Date of Birth (DD/MMM/YYYY):	Emergency Contact Name & Phone No.:		
Address:	City:	Province:	Postal Code:	
Usual / Home Pharmacy:		Primary Care Provider (Family MD, NP):		

Section 2: Screening Questionnaire

In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing, runny nose, feeling unwell?	☐ Yes ☐ No
Have you ever had a **reaction to any immunization** previously (e.g. hives, fainting, difficulty breathing)?	☐ Yes ☐ No
Do you have **allergies** to medications, food (e.g. eggs), vaccine components, or latex? **List:**	☐ Yes ☐ No
Do you take any medications that suppress your immune system or are you immunocompromised?	☐ Yes ☐ No
Do you take any medications (e.g. **blood thinner**) that can affect blood clotting or have a bleeding disorder?	☐ Yes ☐ No
Do you have a history of **Oculo-Respiratory Syndrome**?	☐ Yes ☐ No
Do you have a history of **Guillain-Barré Syndrome** within 6 weeks of any vaccine?	☐ Yes ☐ No
Do you have any **new or changing neurological** conditions?	☐ Yes ☐ No
Are you **pregnant, nursing**, or do you intend to become pregnant?	☐ Yes ☐ No
Have you ever suffered from inflammation of the heart or lining of the heart (**myocarditis/pericarditis**) after a previous dose of a COVID-19 vaccine?	☐ Yes ☐ No
Have you ever had a **COVID-19 infection**? If yes, please indicate **when it was resolved**:	☐ Yes ☐ No
Have you received a **previous dose of COVID-19 vaccine**? If yes, please specify most recent **brand:** & **date:**	

Section 3: Consent Given By Patient/Agent

I, the client, parent or guardian, have read or had explained to me information about the vaccine(s). I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the vaccine(s). I agree to wait in the pharmacy for 15 minutes (or longer, if recommended by a Healthcare Provider) after receiving the vaccine(s).

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine(s). Some serious reactions called "anaphylaxis" can be life-threatening and are deemed medical emergencies. 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 but is not limited to hives, difficulty breathing, and/or 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 were received, or a copy will be provided to my agent or EMS paramedics.

☐ I confirm that I want to receive the vaccine(s) **OR** ☐ I confirm that I want my child to receive the vaccine(s)

Patient/ Agent **Name** (& Relationship)	Patient / Agent **Signature**	**Date** Signed (DD/MMM/YYYY)

PHARMACY USE ONLY Section 4: Vaccine Documentation

☐ **FLULAVAL® TETRA - QIV** DIN: **02420783** 15 mcg/**0.5 mL** (5 mL **multi**-dose vial) **Age 2+**	☐ **FLUZONE® QUADRIVALENT** DIN: **02432730** 15 mcg/**0.5 mL** (5 mL (**multi**-dose vial) **Age 2+**	☐ **FLUZONE® QUADRIVALENT** DIN: **02420643** 15 mcg/**0.5 mL** (0.5 mL **single**-dose syringe) **Age 2+**	☐ **COVID -** Pfizer **KP.2 0.3mL IM** (DIN: 02541823) (**Age 12+**)
☐ **FLUZONE® HIGH-DOSE - QIV** DIN: **02500523** 60 mcg/**0.7 mL** (0.7 mL **single**-dose syringe) **Age 65+**	☐ **FLUAD® TIV - Adjuvanted** DIN: **02362384** 15 mcg/**0.5 mL** (0.5 mL **single**-dose syringe) **Age 65+**	☐ **FLUCELVAX® QUAD** DIN: **02494248** 15 mcg/**0.5 mL** (0.5 mL **single**- dose syringe **Age 2+**	☐ **COVID –** Other: Dose (IM) : **DIN:**

Flu Vaccine	Lot No.:	Expiry: MM/YYYY	Site of Administration: ☐ LEFT Deltoid ☐ RIGHT Deltoid	Time of Immunization:	Date of Immunization (DD/MMM/YYYY)
COVID – KP.2	Lot No.:	Expiry: MM/YYYY	Site of Administration: ☐ LEFT Deltoid ☐ RIGHT Deltoid	Time of Immunization:	

HealthCare Provider's Name & License No.:	HealthCare Provider's Signature:

Adverse Reaction: ☐ Yes ☐ No Emergency Treatment Administered: Name/ DIN: Lot: Exp: Response:

Guardian