

## Section 1: Personal Information

Patient First and Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No. (if applicable):	
<input type="checkbox"/> Male	<input type="checkbox"/> 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:	
COVID-19 Vaccination Status			
<input type="checkbox"/> Received all required doses >14 days ago <input type="checkbox"/> Unimmunized/partially immunized/≤14 days after final dose <input type="checkbox"/> Undisclosed			

## Section 2: COVID-19 Screening

**Note: Every individual who will be present during the administration of the vaccine (regardless of whether you are receiving a vaccine or not) should be screened for COVID-19.**

### Are you experiencing any of the following symptoms?

(If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue, muscle aches and/or joint pain that only began after vaccination, select "No.")

- Fever and/or chills
- New onset of cough or worsening chronic cough
- Shortness of breath
- Decrease or loss of smell or taste
- Fatigue, lethargy, malaise and/or muscle aches (myalgias) (for adults ≥18 years of age)
- Nausea, vomiting and/or diarrhea (for children <18 years of age)

Yes     No

### In the last 10 days, have you tested positive for COVID-19 or have been told that you should be isolating?

Yes     No

### If you are not fully vaccinated\*, please also answer the following two questions.

\* A fully vaccinated individual is defined as any individual >14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series (i.e., Johnson and Johnson).

### Did you travel outside of Canada in the past 14 days?

Yes     No

### Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?

Yes     No

If you respond YES to **ANY** of the screening questions in Section 2, you should not receive a flu shot at the pharmacy at this time and should speak with your pharmacist.

If the responses to **ALL** of the screening questions in Section 2 are **NO**, proceed to Section 3.

## Section 3: Screening Questionnaire

For adult patients as well as parents of children (≥ 2 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 <b>sick today</b> ? (fever greater than 39.5°C, breathing problems, or active infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do <u>NOT</u> get the shot today
Do you have any <b>allergies</b> that you are aware of?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , list what you are allergic to here:
Are you <b>allergic</b> to any of the following? Check all that apply:  <input type="checkbox"/> Thimerosal <input type="checkbox"/> Egg/egg protein/chicken protein <input type="checkbox"/> Kanamycin, neomycin, polymyxin B <input type="checkbox"/> Formaldehyde <input type="checkbox"/> Sodium Deoxycholate <input type="checkbox"/> Triton® X-100 <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Cetyltrimethylammonium bromide (CTAB) <input type="checkbox"/> Polysorbate 80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , your pharmacist can check whether the flu shot contains any of these potential allergens and use one which does not.  (If you have an allergy or reaction to egg/egg protein/chicken protein, speak to the pharmacist. You may be able to receive the flu shot but may <u>require a longer observation period post-administration.</u> )
Are you <b>allergic</b> to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> or <u>UNSURE</u> , do <u>NOT</u> get the shot & <u>SPEAK WITH YOUR MD</u>
Have you had <b>wheezing, chest tightness or difficulty breathing</b> within 24 hours of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any <b>serious allergy</b> to latex or natural rubber?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 <b>Guillain-Barré Syndrome</b> within 6 weeks of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do not get the flu shot and <u>SPEAK WITH YOUR MD</u>
Do you have a <b>new or changing</b> neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do not get the flu shot & <u>SPEAK WITH YOUR MD</u>
Do you have <b>bleeding problems or use blood thinners</b> ? (e.g., warfarin, low dose or regular strength aspirin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , you can get the flu shot but apply gentle pressure afterwards

Seasonal Influenza Vaccine  
Consent Form and Rx Template 2021-22

**Section 4: Consent Given By Patient/Agent**

I, the 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 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 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 2 years of age or older 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, and if written/electronic consent cannot be obtained, the patient/agent has provided verbal consent for the administration of the seasonal influenza vaccine to the patient. Based on my professional judgement, seasonal influenza vaccine should be administered to the patient.

Pharmacist Signature	OCP License #	Date Signed (MM/DD/YYYY)
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**Section 5: Prescription Templates – Pharmacy Use Only**

INFLUENZA VACCINE		EPINEPHRINE EMERGENCY TREATMENT	
Patient Name:		Patient Name:	
<input type="checkbox"/> FLULAVAL TETRA – DIN 02420783 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial (age 2 or older)		<input type="checkbox"/> EpiPen® 0.3 mg/0.3 mL DIN 00509558 – <b>Note: Use the PIN 09857423 for EpiPen 0.3 mg/0.3 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02432730 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial (age 2 or older)		<input type="checkbox"/> EpiPen Junior® 0.15 mg/0.3 mL DIN 00578657 – <b>Note: Use the PIN 09857424 for all EpiPen Junior 0.15 mg/0.3 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02420643 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe (age 2 or older)		<input type="checkbox"/> Allerject® 0.3 mg/0.3 mL DIN 02382067 – <b>Note: Use the PIN 09857440 for Allerject 0.3 mg/0.3 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> AFLURIA® TETRA – DIN 02473313 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial (age 5 or older)		<input type="checkbox"/> Allerject® 0.15 mg/0.15 mL DIN 02382059 – <b>Note: Use the PIN 09857439 for Allerject 0.15 mg/0.15 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> AFLURIA® TETRA – DIN 02473283 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe (age 5 or older)		<input type="checkbox"/> Emerade™ 0.5 mg/0.5 mL DIN 02458454 – <b>Note: Use the PIN 09858130 for Emerade 0.5 mg/0.5 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUCELVAX® QUAD – DIN 02494248 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe (age 2 or older)		<input type="checkbox"/> Emerade™ 0.3 mg/0.3 mL DIN 02458446 – <b>Note: Use the PIN 09858129 for Emerade 0.3 mg/0.3 mL claims for adverse events within the UIIP</b>	
<input type="checkbox"/> FLUZONE® HIGH-DOSE QUADRIVALENT – DIN 02500523 – QIV-HD 60 mcg/0.7 mL – 0.7 mL (single-dose) syringe (age 65 or older)			
<input type="checkbox"/> FLUAD® – DIN 02362384 – TIV-adj 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe (age 65 or older)			
Vaccine Lot #:	Expiry (MM/YYYY):	Number of Doses Administered:	
Date and Time of Immunization:	Location of Immunization: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other:	Date of Administration:	Time(s) of Administration: 1. 2. (if applicable) 3. (if applicable)
Dose mL	Route <b>IM</b>	Site of administration <input type="checkbox"/> Left: <input type="checkbox"/> 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:	