CONSENT AND RELEASE – INJECTABLE VACCINATIONS

Last Name of Patient | First | Middle | Birth date (day/mth/year) ___/___/___ | ❒ Male ❒ Female Sex

Permanent Address | City | Province | Postal Code | Home Phone (___)___-___

Prescriber | Personal Health Number | Weight (1 kg = 2.2 lb)

Emergency Contact | Phone Number

I understand that on the date indicated below, the pharmacist will be administering the vaccine named below at the dose indicated. I understand that the pharmacist: (i) has been trained and is registered to administer injections by the Provincial College of Pharmacists; (ii) is aware of and agrees to comply with all professional standards surrounding administering of injections as well as general pharmacy practice; (iii) maintains current certification in cardiopulmonary rescuscitation (CPR) and basic first aid.

I confirm the pharmacist has given me written information, a copy of which is included with this Consent and Release, about the vaccine being administered as well as the vaccine injection procedure. I acknowledge that I understand the benefits and risks, the expected outcome/reaction as well as the possible side effects of the requested vaccination. I understand and agree to remain at this location for 15-30 minutes after the injection as directed by the pharmacist. I confirm that Red River Co-op, on behalf of its pharmacy operations in all divisions ("Co-op") has answered to my satisfaction all of my questions about the vaccine and the vaccine injection procedure. I understand that I may ask the pharmacist further questions at any time before, during, or after the vaccine injection.

I understand that I am giving Co-op permission to release any medical or other information necessary to my physician, provincial health care, or insurance company or immunization registry, as applicable, to enable Co-op to process my insurance claims with respect to the vaccination.

In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary life saving procedures as an interim measure until medical support personnel arrive. In case of emergency, please contact the person I have named above as an Emergency Contact. I, for myself (and for the recipient of the vaccination, if the recipient is a minor), my heirs, executors and assigns hereby ACKNOWLEDGE AND AGREE THAT I AM VOLUNTARILY PARTICIPATING IN THIS ACTIVITY WITH THE KNOWLEDGE OF THE RISKS INVOLVED AND ASSUME ALL RISKS ASSOCIATED WITH THE ADMINISTRATION AND THE VACCINE AND release Co-op and its divisions and affiliates and their respective officers, directors, employees, agents and representatives from any and all claims arising out of or in connection with the quality of the above-described vaccine(s) as provided by the manufacturer and any negligence of Co-op in connection with the related injection of the vaccination. I understand that the laws of my province may affect my remedies in connection with this vaccination.

By checking this box ❒ I authorize that in the event of a needlestick injury involving the immunizer, to provide my consent to obtain further blood sampling for evaluation (if required) and that the results of such tests can be made known to the immunizer.

I have read and understand the above information. I request and consent that the vaccine be given, as I direct Co-op, either to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent and Release.

X ___ Signature of Person to Receive Vaccine/Parent or Guardian of Minor | Date | Print Name of Parent or Guardian/Phone #

Please answer these questions by checking the boxes. If the question is not clear, please ask the pharmacist.			Yes	No	Unknown
Vaccine History	1.	All Patients: How long has it been since your last **TETANUS** shot? _____ years	❒	❒	❒
	2.	Patients 65 years or older, patients that have chronic lung disease or diabetes and patients that smoke: Have you ever received the **PNEUMONIA** vaccine?	❒	❒	❒
	3.	Patients 50 years of age or older: Have you ever received the **SHINGLES** vaccine?	❒	❒	❒
All	4.	Are you **sick today**?	❒	❒	❒
	5.	Do you have a **serious allergy** to ANY medications or food? (Example: Eggs, Gelatin, Thimerosal, Neomycin, Gentamicin). If Yes, please list: _____.	❒	❒	❒
	6.	Have you ever had a **serious reaction or fainted after receiving any vaccination**?	❒	❒	❒
	7.	Do you have sensitivity to **latex**? (example: gloves or bandages)	❒	❒	❒
	8.	**For women**: Are you pregnant or are you considering becoming pregnant?	❒	❒	❒
Tdap	9.	Do you have a seizure disorder or a brain disorder? (For pertussis containing vaccines)	❒	❒	❒
Live	10.	Have you received any vaccination in the past 4-6 weeks? Which ones: _____	❒	❒	❒
	11.	Do you have cancer, leukemia, HIV, active shingles or any other **immune system problem**?	❒	❒	❒
	12.	Do you take prednisone, oral steroids, anticancer drugs, antiviral medications or medications that affect the immune system?	❒	❒	❒
	13.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin or had radiation therapy?	❒	❒	❒

----------BELOW LINE FOR PHARMACY USE ONLY----------

Check Box to Confirm Patient Identity Verified ❒ **Check box to Confirm Vaccine/Drug to be administered Verified ❒**

Vaccine	Lot# of Vaccine	Exp Date	Manufacturer	Dosage	Site of Injection	Time	Written Info to Pt.?
					IM L / R Deltoid SC L / R PLUA		
					IM L / R Deltoid SC L / R PLUA		
					IM L / R Deltoid SC L / R PLUA		

Signature of Pharmacist/Title: _____ **Written info and verbal counseling provided to patient ❒**