Vaccination Consent and Record of Administration

Date | Name | Provincial Health Number

Address | Street | Town, Province | Postal code

Phone Number | Email

Date of Birth | Age | Male | Female | Weight:

Emergency Contact Name | Phone

Relationship

Screening Checklist	Yes	No	Notes
Are you sick today? Do you or have you had a fever in the last 3 days?	○	○	
Have you had an allergic reaction to a flu shot in the past?	○	○	
Do you have any allergies? (including medication, eggs, latex, fruit)	○	○	
Have you received any vaccinations in the last 6 weeks?	○	○	
Have you ever had a serious reaction to a vaccine? (fainting, Guillain Barre Syndrome)	○	○	
Do you have any conditions which affect your Immune system (Cancer, HIV etc.)	○	○	
Are you taking any medications which affect your immune system? (prednisone, chemotherapy, etc.)	○	○	
Have you received a blood transfusion, given immune globulin, or received radiation in the last year?	○	○	
Women: Are you pregnant or planning to get pregnant within the next month?	○	○	

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Consent Given by Patient/Agent

I, the undersigned client, parent or guardian, acknowledge that the pharmacist has provided me with the information pertaining to the drug being administered as well as the injection procedure so that I understand the expected outcome/reaction as well as the possible side effects. I understand that I may ask the pharmacist further questions at any time before, during or after the injection.

I understand that the pharmacist has been trained by and is registered by the provincial regulatory authority to administer injections. The pharmacist is aware of and agrees to comply with all professional standards surrounding the administration of injections.

I understand that the pharmacist maintains current certification in CPR and First Aid. In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply lifesaving procedures as an interim measure until medical support personnel arrive. In case of emergency, please contact the person I have named on the previous page.

I understand that if required by provincial regulations or deemed necessary by the pharmacist, my primary care provider and or Public Health will be notified that I have received this injection.

I understand and agree that I am to remain at this location for 15 to 30 minutes after the injection as instructed by the pharmacist.

I understand and agree that I will provide a blood sample for further testing in the event of a needlestick injury to the pharmacist.

Patient Name: _____

Signature:
(parent or guardian if a minor) _____

Pharmacy Use Only:

Vaccine administered	
Route/Site of administration	
Lot	
Expiry	
Dosage	
Date and Time	
Pharmacist Name	
Pharmacist Signature	

Alberta Only:

Reason codes	Pregnant
Healthcare worker:	9-64 yrs
65 or Older:	