2018/19 INFLUENZA VACCINE CONSENT FORM

Patient Full Name _____

Address _____

_____

_____

Emergency Contact _____

Emergency Contact Phone Number _____

Date of Birth _____ (dd/mm/yyyy)

Phone Number _____

Health Card Number _____

Gender Male ☐ Female ☐

Note: Under BC provincial legislation, pharmacists cannot give injections to children under 5 years of age and cannot administer an intranasal drug to children under 2 years of age.

As of today:	Yes	No
Have you ever had a flu shot before?		
Have you ever fainted or had a serious reaction to any previous injection or vaccine(s)?		
Have you received any vaccinations in the last 6 weeks?		
Do you have a fever, infection, or feel unwell?		
Do you have any allergies? Please list:		
Do you have any chronic health conditions or immunodeficiencies? Please list:		
Are you currently on any medications or immunosuppressants? Please list:		
Do you have an active neurological condition?		
Are you pregnant or breastfeeding?		
Have you received blood products (containing immunoglobulin) in the last 3 months?		

PATIENT CONSENT

- I have read or had explained to me and understand the benefits, side effects and risks of receiving the influenza vaccine.
- I have had the opportunity to ask questions and I have received satisfactory answers.
- I agree to stay in the pharmacy for at least 15 minutes after receiving the influenza vaccine.
- I authorize the pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction.

AND: ☐ I consent to receive the influenza vaccine today. **OR** ☐ I consent for my child or dependent to receive the influenza vaccine today.

Print Name _____ Signature _____

Date _____

PHARMACIST USE ONLY:

Influenza Vaccine	Dosage: 0.5mL ☐	Other	**Administration Site**	Deltoid: R ☐ L ☐ Other _____	**Notes/Observations (15-30min wait)**
☐ FluMist*	☐ Fluviral	☐ Fluzone	**Administration Route**	IM ☐ Intranasal ☐ Intradermal ☐	
☐ Influvac	Other _____		**Immunization Date**		
	_____		**Immunization Time**		
Lot No.			**Pharmacist Name**		
			RPh License No.		
Expiry Date			**RPh Signature**		

*PharmaCare does not pay an administration fee

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