2021-2022 Seasonal Influenza (Flu) Vaccine Consent Form

Section 1: Patient Information

Last Name:	First Name:	Prov. Health Number:	Gender:	
Main Phone Number:	Alternate Phone Number:	Date of Birth (MM/DD/YYYY):	Age:	Child's weight: (kg / lb)
Address:	City:	Province:	Postal Code:	
Emergency Contact's Last Name:	Emergency Contact's First Name:	Relationship:	Emergency Contact's Main Phone Number:	
Emergency Contact's Alternate Phone Number:		Ask your pharmacist about age restriction for flu shots in a pharmacy		

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, sore throat, runny nose, feeling unwell?	☐ Yes ☐ No
Have you ever had a reaction to any immunization previously?	☐ Yes ☐ No
Do you have allergies to medications, food (eg. eggs), vaccine components or latex?	☐ Yes ☐ No
Are you currently under a physician's care for any medical condition (active neurological disorder)?	☐ Yes ☐ No
Do you have any heart, lung or diabetic condition?	☐ Yes ☐ No
Have you had close contact with anyone with a severely weakened immune system?	☐ Yes ☐ No
Do you have a history of Oculo-Respiratory Syndrome?	☐ Yes ☐ No
Do you have a history of Guillain-Barre Syndrome within 6 weeks of getting a flu shot or had difficulty breathing within 24 hours of getting a flu shot?	☐ Yes ☐ No
Are you pregnant, nursing, or do you intend to become pregnant?	☐ Yes ☐ No
Are you currently taking or planning to take any seizure, immunosuppressants, antivirals, rheumatoid arthritis, Crohn's disease, psoriasis, or aspirin containing therapy?	☐ Yes ☐ No
Have you received a full COVID-19 vaccine course? ☐ Yes ☐ No Shingles vaccine? ☐ Yes ☐ No Pneumonia vaccine? ☐ Yes ☐ No	

Section 3: Consent Given By Patient/Agent

I, the undersigned patient, parent or guardian, have read or have had explained to me information about the seasonal influenza vaccine ("Vaccine") as outlined on the Flu Vaccine 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 Vaccine. After getting the Vaccine, I agree to wait in the clinic/pharmacy for 15 minutes (or the time recommended by the pharmacist).

I am aware it is possible (yet rare) to have an extreme allergic reaction to any component of the Vaccine. Serious reactions called "anaphylaxis" can be life- threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following vaccination, I am aware it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to treat this reaction and 9-1-1 will be called to provide additional assistance. In the event of anaphylaxis, I, my agent, and/or EMS paramedics will receive a copy of this form. I understand the information contained on this form, may be disclosed to the public health authority and to other required parties for the purpose of adverse event and drug safety reporting.

☐ I confirm that I want to receive the seasonal influenza vaccine **OR** ☐ I confirm that I want my child to receive the seasonal influenza vaccine

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

PHARMACY USE ONLY Section 4: Prescription Templates Influenza Vaccine Used

HEALTH CARE PROVIDER'S DECLARATION:
☐ I confirm the above named patient is capable of providing consent for the seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient. I am administering the seasonal influenza vaccine no more than 21 days after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient.

☐ **FLUMIST® QUAD** 0.1mL per nostril DIN 02426544	☐ **FLUAD Pediatric®** 0.25mL IM DIN 02434881	☐ **FLUAD®** 0.5mL IM DIN 02362384	☐ **FLUZONE® High-Dose QUAD** 0.7mL IM DIN 02500523	☐ **FLUVIRAL®** 0.5mL IM DIN 02420686	☐ **OTHER**
☐ **FLULAVAL® TETRA** 0.5mL IM DIN 02420783	**AFLURIA® TETRA** ☐ 0.5mL IM pre-filled syringe DIN 02473283 ☐ 5mL IM multi-dose vial DIN 02473313	**FLUCELVAX® QUAD** ☐ 0.5mL IM pre-filled syringe DIN 02494248	**FLUZONE® QUAD** ☐ 0.5mL IM single-dose vial DIN 02420643 ☐ 5mL IM multi-dose vial DIN 02432730	☐ **INFLUVAC® TETRA** 0.5mL IM DIN 02484854	

Date of Immunization (MM/DD/YYYY):	Time of Immunization:	Vaccine Lot #:	Vaccine Expiry (MM/YYYY):	Health Care Provider's Name &License #:	Signature:

Site of Administration: ☐ Left Arm ☐ Right Arm ☐ Intranasal		Contacted Primary Prescriber: ☐ Yes ☐ No	Emergency Treatment: ☐ Yes (see attached) ☐ No
NS Only	Patient condition before:	Response during:	Response immediately after: