Rexall™ FluShot

Patient Consent for Flu (Influenza) Immunization

By provincial legislation, Pharmacists cannot administer a flu shot to children under a certain age. Ask your pharmacist for age restrictions.

Name:			Provincial Health Number:
Gender:		Email :	
Date of Birth (MM/DD/YYYY):	Age:	Pregnant: ☐ Yes ☐ No ☐ N/A	Patient Phone:
Address:			Child's Weight: kg or lb
Emergency Contact Name:			Contact Phone:
Relationship to Patient:			
Family Physician Name:			Physician Phone:

Injection Screening Questionnaire	Yes	No
1. Do you or have you had a fever within the past 3 days?		
2. Have you ever had a reaction to any immunizations previously?		
3. Do you have allergies to medications, food (e.g. eggs), vaccine components, or latex?		
4. Are you currently under a physician's care for any medical condition (e.g. active neurological disorder)?		
5. Do you have any heart, lung, or diabetic condition?		
6. Have you had close contact with anyone with a severely weakened immune system?		
7. Do you have a history of Oculo-Respiratory Syndrome?		
8. 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?		
9. Have you received your Shingles vaccines?		
10. Have you received your Pneumonia Vaccine?		

Are you currently taking any of the following prescription medications?	Yes	No		Yes	No
Prednisone or other immunosuppressants			Drugs for rheumatoid arthritis, Crohn's disease or psoriasis		
Coumadin (Warfarin) or other blood thinners			Antiviral Drugs		
Phenytoin or other anti-epilepsy medications			Other (Specify):		
Theophylline					

Note: If you answered **YES** to any of the above questions, the Pharmacist will ask you further questions. Pending your response, you may not be eligible to receive an influenza vaccine today.

Consent Given By Patient/Agent

I, the undersigned patient, parent or guardian, have read or had explained to me information about the vaccine as outlined on the vaccine monograph. 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. I agree to wait in the clinic/pharmacy for 15 minutes after getting the shot.

☐ 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/Guardian Name:

Patient/Guardian Signature: Date:

Pharmacy Use Only

Vaccine Name:

☐ AGRIFLU® ☐ VAXIGRIP® ☐ INTANZA® ☐ FLUAD® ☐ FLUZONE® HD ☐ FLULAVAL®
☐ FLUZONE QIV® ☐ FLUVIRAL® ☐ INFLUVAC® ☐ AFLURIA TETRA® ☐ Other:

Date of Vaccine: Time of Vaccine: Vaccine Lot#:

Dose: Expiry:

Route: ☐ IM ☐ SC ☐ NAS Site: ☐ Left Arm ☐ Right Arm

AB ONLY

☐ (3) Healthcare workers
☐ (2) 65+
☐ (46) Pregnant
☐ 5-64

SK ONLY

☐ On-site
☐ Off-site
☐ 5-8 (2 fees/yr. – 1st time)

Additional Notes (including emergency measures taken or patient follow-up):

Child between the ages of 6 months to less than 9 years getting vaccinated for 1st time: Yes ☐ No ☐
If Yes, schedule 2nd flu shot in 28 days
Date: _____

PHARMACIST'S DECLARATION: I confirm that I have communicated the risks and benefits associated with the vaccine. I have reviewed the patient record and find that the vaccine should be given to the patient.

Pharmacist Name:	License #:	Date:
Pharmacist Signature:		