Rexall™ FluShot

Influenza (Flu) Informed Consent

Date:	Name:	Provincial Health Number:
☐ I have recently filled a prescription at this location. If yes, skip to questionnaire.	Address:	
City:	Postal Code:	
Home Phone:	Mobile Phone:	
Email:	Date of Birth (MM/DD/YYYY):	Male ☐ Female ☐ Age: Child's Weight: Kg lb
Emergency Contact Name:	By provincial legislation, Pharmacists cannot administer a flu shot to children under a certain age. Ask your pharmacist for age restrictions.	
Emergency Contact's Relationship to Patient:	Contact's Phone Number:	

Flu Vaccine Questionnaire	Yes	No	Notes
Do you or have you had a fever within the past 3 days?			
Have you ever had an allergic reaction to a flu shot?			
Do you have an active neurological disorder?			
Have you ever experienced difficulty breathing within 24 hours of getting a flu shot?			
Are you or do you think you might be pregnant?			
Are you allergic to eggs or egg products? Contact lens solution? Formaldehyde? Neomycin? Thimerosal?			
Are you taking any of these medications? Prednisone or other immunosuppressants, Coumadin(warfarin) or other blood thinners, phenytoin or other anti-epilepsy medications or theophylline?			
Do you have a history of : Guillian-Barre Syndrome within 6 weeks of getting a flu shot? Oculo-Respiratory Syndrome?			
Are you currently taking any prescription medications?			
Are you currently under a physician's care for any medical condition?			
Are you over 65? ☐ Yes ☐ No Have you received a Pneumoccal Vaccine in the last five years? ☐ Yes ☐ No			
Are you over 50? ☐ Yes ☐ No Have you ever had Chicken Pox? ☐ Yes ☐ No Have you received a Zoster (Shingles) Vaccine? ☐ Yes ☐ No Have you received a Tetanus vaccine in the last ten years? ☐ Yes ☐ No			
NOTE: If you answered YES to any of the above questions, the nurse or pharmacist will ask you further questions. Pending your response, you may not be eligible to receive an influenza vaccination today.			

OVER ▶

Rexall™/MC FluShot Influenza (Flu) Informed Consent

Consent Given By Patient/Agent

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

☐ **Yes,** I consent that my information may be used to notify me of other pharmacy related services.

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

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

Health Care Provider's Signature	Health Care Provider's License #	Date Signed (MM/DD/YYYY)

Pharmacy Use Only

INFLUENZA VACCINE TO BE USED Dosage: 0.5 mL IM

☐ AGRIFLU® ☐ VAXIGRIP® ☐ INTANZA® ☐ FLUMIST®
☐ FLUAD® ☐ FLUVIRAL® ☐ INFLUVAC®
☐ FLULAVAL™ TETRA ☐ FLUZONE® QUADRIVALENT

Vaccine Lot#: Site: Arm ☐ Left ☐ Right

Vaccine Expiry Date: (MM/YYYY)

Date of Immunization: (MM/DD/YYYY) ☐ Same as above.

Time of Immunization:

AB ONLY

☐ (2) Over age 65 ☐ (01B) High Risk (9-17) ☐ (3) HC Worker
☐ (59B) Healthy (9-17) ☐ (01C) High Risk (18-64) ☐ (44) LTC Staff
☐ (59C) Healthy (18-64) ☐ (46) Pregnant ☐ (22A) LTC Resident (65+)
☐ (22B) LTC Resident (>65)

EPINEPHRINE TREATMENT (if required)

EPIPEN® *(If weight is > 30 kg or 66 lbs)*

EPIPEN® Junior *(If weight is between 15-30 kg or 33-66 lbs)*

Number of Doses Administered:

Time(s) of Administration: (1) (2) (if applicable)

Health Care Provider's Signature:

Health Care Provider's License#:

Date & Time of Follow-up with Patient/Agent:

PNEUMOCOCCAL POLYSACCHARIDE VACCINE ☐ PNEUMOVAX ☐ PREVNAR

Dosage: 0.5 mL IM

Expiry Date : Lot Number:

Site: Arm ☐ Left ☐ Right

Date of Immunization: (MM/DD/YYYY) ☐ Same as above.

Time of Immunization:

Priority use by Reason (AB ONLY) :

	Routine recommended immunization
	Medically at Risk
	High Risk Setting

ZOSTER VACCINE (ZOSTAVAX)

Dosage: 0.5 mL IM

Expiry Date : Lot Number:

Site: Arm ☐ Left ☐ Right

Date of Immunization: (MM/DD/YYYY) ☐ Same as above.

Time of Immunization:

NOTES:

The immune response to Zostavax is diminished when Pneumovax and Zostavax are given concurrently.

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