

2020-2021 Seasonal Influenza (Flu) Vaccine Consent Form

| Section 1: Patient Information | | | | Date (MM/DD/YYYY): | |
|---|---------------------------------|---|--|------------------------------|--|
| 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 Refer to <u>Screening Questionnaire Action Guide</u> for recommendations | | Yes | No |
|---|---|-----|----|
| Are you, or have you been sick within the past 3 days? (fever greater than 39.5°C, breathing problems, or active infection) | | | |
| Have you had difficulty breathing, wheezing or chest tightness within 24 hours of getting an influenza vaccine? | | | |
| Are you allergic to any part of the influenza vaccine, or have you had a severe, life-threatening allergic reaction to a past influenza vaccine? | | | |
| Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to: • Contact lens solution • Egg or egg products • Formaldehyde • Gelatin • Gentamicin • Kanamycin • Neomycin • Thimerosal • Polymyxin B | | | |
| Do you have a serious allergy to latex or natural rubber? | | | |
| Have you had a reaction to eggs or egg products but can still eat small amounts of egg? (eg. Stomach ache, skin reaction) | | | |
| Have you had Guillian-Barré Syndrome within 6 weeks of getting an influenza vaccine? Oculo-Respiratory Syndrome? | | | |
| Have you ever had a seizure or have an active, new, or changing neurological disorder? | | | |
| Do you have bleeding problems or use blood thinners? (eg. Warfarin) | | | |
| Are you pregnant, nursing, or do you intend to become pregnant? | | | |
| Have you received your pneumonia vaccines? If yes, which vaccine _____ and when: _____ | | | |
| Have you received your shingles vaccines? If yes, which vaccine _____ and when: _____ | | | |
| Only fill this section if planning to receive the nasal influenza vaccination | Have you received any vaccines in the last 4 weeks? | | |
| | For children under 18 years old: Is the child using, or will be using an aspirin/aspirin-containing therapy in the next 4 weeks? | | |
| | Do you have severe asthma (on high dose inhaled or oral corticosteroids) or medically attended wheezing in the past 7 days? | | |
| | Have you received in the past 48 hours or do you intend to receive in the next 2 weeks flu antiviral therapy? (eg. Oseltamivir)? | | |
| | Do you have any medical conditions (eg. Cancer, leukemia, HIV/AIDS) or take medications that weaken the immune system? | | |
| | Do you provide health care services to or do you have close contact with persons who are immunocompromised? | | |
| | Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to Arginine? | | |

| Section 3: Consent Given By Patient/Agent | | |
|---|-------------------------|--------------------------|
| <p>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).</p> <p>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.</p> | | |
| <input type="checkbox"/> I confirm that I want to receive the seasonal influenza vaccine OR <input type="checkbox"/> 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: | | | | | | |
| <input type="checkbox"/> 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 <u>21 days</u> after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient. | | | | | | |
| <input type="checkbox"/> AGRIFLU® 0.5 mL IM DIN 02346850 | <input type="checkbox"/> FLUAD Pediatric® 0.25 mL IM DIN 02434881 | <input type="checkbox"/> FLUAD® 0.5 mL IM DIN 02362384 | <input type="checkbox"/> INFLUVAC® 0.5 mL IM DIN 02269562 | <input type="checkbox"/> FLUVIRAL® 0.5 mL IM DIN 02420686 | <input type="checkbox"/> FLUZONE High-Dose® 0.5 mL IM DIN 02445646 | <input type="checkbox"/> FLUMIST® 0.1mL per nostril DIN 02426544 |
| <input type="checkbox"/> FLULAVAL® TETRA 0.5mL IM DIN 02420783 | <input type="checkbox"/> AFLURIA® TETRA <input type="checkbox"/> 0.5mL IM pre-filled syringe DIN 02473283 <input type="checkbox"/> 5mL IM multi-dose vial DIN 02473313 | <input type="checkbox"/> FLUCELVAX® QUAD <input type="checkbox"/> 0.5mL IM pre-filled syringe DIN 02494248 <input type="checkbox"/> 5mL IM multi-dose vial DIN 02494256 | <input type="checkbox"/> FLUZONE® QUAD <input type="checkbox"/> 0.5mL IM single-dose vial DIN 02420643 <input type="checkbox"/> 5mL IM multi-dose vial DIN 02432730 | <input type="checkbox"/> INFLUVAC® TETRA 0.5mL IM DIN 02484854 | <input type="checkbox"/> OTHER | |
| 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: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Intranasal | | Contacted Primary Prescriber: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Emergency Treatment: <input type="checkbox"/> Yes (see attached) <input type="checkbox"/> No | | |
| NS Only | Patient condition before: | Response during: | | Response immediately after: | | |