## 2020 2021 Seesanal Influenza (Flu) Vaccine Consent Form

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Last Name   Prone Number:   Alternate Prone Number:   Date of Birth (MMDDYYYY):   Age:   Child's weight (%)	Section 1: I	Patient Informati	on			Date (	MM/DD/Y	YYY):			
City   Province:					Prov. Health N	Prov. Health Number:		Gender:			
Emergency Contact's Last Name: Emergency Contact's First Name: Emergency Contact's Alternate Phone Number: Ask your pharmacist about ago restriction for flu shots in a pharmacy:  Section 2: Screening Questionnaire Refer to Screening Questionnaire Anton Guide for recommendations  Are you or here you been ack within the past 3 days? (fewer greater than 38 5°C. Investing grottlerns, or active infection)  Here you had disturbly breaking, whencome or the influence vector, or here you had a recommendation or the past of the influence vector, or here you had a reaction to egge or egg products + Formaldehyle - Gelatin - Gentantich - Kananycin - Noomycin - Thimerosal-Polymydri B by Oyou have a reaction to egge or egg products but can still cut amail amounts of egg? (eg. Stomech eths, shin reaction)  Have you had a reaction to eggs or egg products but can still cut amail amounts of egg? (eg. Stomech eths, shin reaction)  Have you had a reaction to eggs or egg products but can still cut amail amounts of egg? (eg. Stomech eths, shin reaction)  Have you had a reaction to eggs or egg products but can still cut amail amounts of egg? (eg. Stomech eths, shin reaction)  Have you had a reaction to eggs or egg products but can still cut amail amounts of egg? (eg. Stomech eths, shin reaction)  Have you had a reaction to eggs or egg products but can still cut amail amounts of egg? (eg. Stomech eths, shin reaction)  Have you had a reaction to eggs or egg products but can still cut amail amounts of egg? (eg. Stomech eths, shin reaction)  Have you be reacted your preserved your p	Main Phone Number:		Alternate Phone N	lumber:	Date of Birth (N	Date of Birth (MM/DD/YYYY):		Age:		(kg /	
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Section 2: Screening Questionnaire Refer to Refer R	Emergency Conta	act's Last Name:	Emergency Contac	ct's First Name	e: Relationship: Emergency Contact's			act's Main	s Main Phone Number:		
Are you, or have you been sick within the past 3 days? (fewer greater than 38.5°C, breathing problems, or active infection)	Emergency Contact's Alternate Phone Number:  Ask your pharmacist about age restriction for flu shots in a pharmacist about age restriction for flu shots in a pharmacist about age restriction for flu shots in a pharmacist									rmacy	
Have you had difficulty breathing, wheezing or chest fightness within 24 hours of getting an influenza vaccine?  Are you allergic (eg. Wheezing, chest fightness, difficulty breathing, these) for contact lens southin = 6 gar operators. For manifoldity of solidars, contact lens southin = 6 gar operators. For manifoldity of solidars, chest is contact lens southin = 6 gar operators. For manifoldity of solidars of solidars. For manifoldity of so	Section 2: Screening Questionnaire Refer to Screening Questionnaire Action Guide for recommendations									Yes	No
Are you allergic to any part of the influenza vaccine, or have you had a server, life-threatening allergic reaction to a past influenza vaccine?											
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Contact lens solution - Egg or egg products - Formaldehyde - Gelatin - Gentanicin - Kanamycin - Neomycin - Thimerosal-Polymyxin B   Do you have a serious allergy to late or natural rather or											
Have you had a reaction to aggs or agg products but can still eat small amounts of agg? (eg. Stomach ache, skin reaction)  Have you vare had a selzure or have an active, new, or changing neurological disorder?  Do you have bleeding problems or use blood thinners? (eg. Warfarin)  Are you pregived you shriped to become pregnant?  Have you received your pregived you shriped to become pregnant?  Have you received your bringets excluses? If yes, which vaccine and when:  Have you received your bringets exclusive? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your shripeds vaccines? If yes, which vaccine and when:  Have you received your predents of your shriped your your shriped your your your your your your your your	Contact lens solution • Egg or egg products • Formaldehyde • Gelatin • Gentamicin • Kanamycin • Neomycin • Thimerosal • Polymyxin B										
Have you ever had a seizure or have an active, new, or changing neurological disorder?  Do you have blooding problems or use blood thinners? (e.g. Warfam)  Are you pregnant, nursing, or do you intend to become pregnant?  Have you received your prelimination accines? If yee, which vaccine  Have you received your prelimination accines? If yee, which vaccine  Have you received your prelimination accines? If yee, which vaccine  Have you received your prelimination accines? If yee, which vaccine  Bay our received your prelimination accines? If yee, which vaccine  Have you received your prelimination accines? If yee, which vaccine  Bay our received your prelimination accines? If yee, which vaccine  Bay our received your prelimination accines? If yee, which vaccine  Bay our prelimination accines and the field 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?  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 server eatthma (child prelimination) and the prelimination accines and											<del>                                     </del>
Section 3: Consent Given By Patient/Agent   Line undersigned patient parent or guardian, have read or have his explained to may include the seasonal influenza vaccine ("Ace you pregenced, and when: "   Section 3: Consent Given By Patient/Agent   Line was the information about the seasonal influenza vaccine ("Ace you pregenced, and when: "   Section 3: Consent Given By Patient/Agent   Line undersigned patient, parent or guardian, have read or have had explained to may include hives, difficulty breathing, which patient and undersigned patient, parent or guardian, have read or have had explained to may include hives, difficulty breathing, which is passed the time to apply the passed with the pass of the time to do you have does contact with persons who are immunocompromised?   Section 3: Consent Given By Patient/Agent   Line undersigned patient, parent or guardian, have read or have had explained to me information about the seasonal influenza vaccine ("Ace you dilegic (eg. Wheezing, cheet light here as exprised to a part of you have decided in an anywer were given to my satisfaction. I understand the risks and benefits of receiving the Vaccine, Large to wait in the clinic/pharmacy for 15 minutes (or the time recommended by the pharmacis). Large was the passed by the pharmacis). Large was the passed by the pharmacis of the vaccine, Large to wait in the clinic/pharmacy for 15 minutes (or the time recommended by the pharmacis). Large was the passed by the pharmacis). Large was the passed by the pharmacis of the tongue, throat, and/or lips, if I experience such symptoms following vaccination, in an aware it may require the administration of paring the harden in the vaccine. Patient/Agent Name (& Relationship)    Patient/Agent Name (& Relationship)   Patient/Agent Signature   Patient/Agent Name (& Relationship)   Patient/Agent Signature   Patient/Agent Name (& Relationship)   Patient/Agent Signature   Patient/Agent Name (& Relationship)   Patient/Agent Name (& Relationship)   Patient/Agent Name (& Relationship)   Pat	7 77 77 77 77 77 77 77 77 77 77 77 77 7										
Do you have subseding problems or use blood thinners? (eg. Warfarin)  Are you pregnant, nursing, or do you intend to become pregnant?  Have you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you received your pseumonia vaccines? If yes, which vaccine  ## you great your your your your your your your your	, , , , , , , , , , , , , , , , , , , ,										
Ace you pregnant, nursing, or do you intend to become pregnant?	· · · · · · · · · · · · · · · · · · ·										
Have you received your shingles vaccines? If yes, which vaccine   and when:	, ,										
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 astmma (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. Osellamivir)? Do you have any medical conditions (eg. Cancer, Leukemia, HIV/NDIS) or lack 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 aliergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to Arginine?  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 clinicipharmacy for 15 minutes (or the time recommended by the pharmacist).  I am aware it is possible (vet 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 than your component of the Vaccine. Serious reactions called "anaphylaxis" can be life- threatening medical emergencies. Symptoms of an anaphylactic reaction to any component of the Vaccine. Serious reactions called "anaphylaxis" can be life- threatening medical emergencies. Symptoms of an anaphylactic reaction to any component of the Vaccine. Serious reactions called "anaphylaxis" can be life- threatening medical emergencies. Symptoms of an anaphylactic reaction that provide additional assistance. In the event of anaphylaxis, it, my agent, andor EMS pa											
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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.    AGRIFLU®	understand the information contained on this form, may be disclosed to the public health authority and to other required parties for the purpose of advers										
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Date of Immunization (MM/DD/YYYY):  Time of Immunization:  Vaccine Lot #: Vaccine Expiry (MM/YYYY):  Health Care Provider's Name & Signature:  License #:  Site of Administration:  Left Arm  Right Arm  Intranasal Contacted Primary Prescriber:  Yes  No Emergency Treatment:  Yes (see attached)  No	DIN 02420783										
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