Pharmacy101
Seasonal Influenza Vaccine

464 Division Street Cobourg, Ontario K9A 3S2
ph 905.372.8808 fax 905.372.4667
www.pharmacy101.ca

Screening Questionnaire and Consent Form For Inactivated Injectable Influenza Vaccine

Section 1: Personal Information

Patient First & Last Name:	Weight:	Patient OHIP No.:
Patient Address:	City	Postal code:
☐ Male ☐ ☐ Female (Fill in the blank)	Date of Birth: (DD/MM/YYYY)	Age:	Patient Telephone Number:
Name of Emergency Contact:	Emergency Contact's Relationship to Patient:	Contact's Phone Number:

Section 2: Screening Questionnaire

For adult patients as well as parents of children (5 years and older) to be vaccinated:
The following questions will help us determine if there is any reason you or your child should not get the flu shot today. If you answer "yes" to any question, it does not necessarily mean the shot cannot be given. It simply means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

COVID-19 Screening questions:	Yes	No	Unsure	Action required
Are you **sick today**? (fever greater than 39.5 °C, new onset of cough, worsening chronic cough, shortness of breath or difficulty breathing, or active infection)	☐	☐	☐	If *YES*, do **NOT** get the shot today
Have you had close contact with anyone with acute respiratory illness or have you travelled outside of Canada in the past 14 days?	☐	☐	☐	If *YES*, do **NOT** get the shot today

Do you have any two (2) of the following symptoms: ☐ None of the listed symptoms

- ☐ Sore throat
- ☐ Headache
- ☐ Chills
- ☐ Hoarse voice
- ☐ Nasal congestion/runny nose
- ☐ Difficulty swallowing
- ☐ Pink eye (conjunctivitis)
- ☐ Fast heart rate
- ☐ Low blood pressure (for your age)
- ☐ Decreased or loss of sense of smell
- ☐ Unexplained fatigue/malaise/muscle aches
- ☐ Nausea/vomiting, diarrhea, abdominal pain
- ☐ New or unusual worsening of chronic conditions

If you are older than 70 years of age, are you experiencing any of the following symptoms?
☐ Delirium ☐ Acute functional decline ☐ Unexplained or increased number of falls
☐ Not applicable – I am less than 70 years of age ☐ None of the listed symptoms

Influenza-immunization specific questions:	Yes	No	Unsure	Action required
Are you **allergic** to any medications including vaccines?	☐	☐	☐	If YES, list what you are allergic to here:
Are you **allergic** to any of the following? Check all that apply: ☐ Thimerosal ☐ Egg protein	☐	☐	☐	If YES, your pharmacist can check whether the flu shot contains any of these potential allergens and use one which does not.
Are you **allergic** to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?	☐	☐	☐	If *YES*, or *UNSURE*, do **NOT** get the shot & speak with your MD
Have you had **wheezing, chest tightness or difficulty breathing** within 24 hours of getting a flu shot?	☐	☐	☐	
Have you had a reaction to **eggs** or **egg products**?	☐	☐	☐	If *YES*, or *UNSURE*, speak with the pharmacist. You CAN receive the flu shot (may require longer observation post-injection)

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Section 2: Screening Questionnaire (continued)	Yes	No	Unsure	Action required
Do you have any **serious allergy** to latex or natural rubber?	☐	☐	☐	If *YES*, or *UNSURE*, you can receive the flu shot, but non-latex materials are to be used
Have you had **Guillain-Barré Syndrome** within 6 weeks of getting a flu shot?	☐	☐	☐	If *YES*, do **NOT** get the shot& speak with your MD
Do you have a **new or changing** neurological disorder?	☐	☐	☐	If *YES*, do **NOT** get the shot & speak with your MD
Do you have **bleeding problems or use blood thinners**? (e.g. warfarin, low dose or regular strength aspirin)	☐	☐	☐	If *YES*, shot can be given but apply gentle pressure afterwards

Section 3: 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 pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu shot.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips.

In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐ **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**

Print Patient Name	Patient / Parent **Signature**	Date Signed (DD/MM/YYYY)

Section 4: Prescription Templates – Pharmacy Use Only

☐ **FLULAVAL TETRA®** – DIN 0242 0783 – QIV 15mcg/0.5mL – 5mL (multi-dose) vial	☐ **FLUZONE Quadrivalent®** 15mcg/0.5mL – QIV DIN 0243 2730 – 5mL (multi-dose) vial ☐ DIN 0242 0643 – 0.5mL pre-filled (single-dose) syringe
☐ **FLUCELVAX QUAD®** – DIN 0249 4248 – QIV 15mcg/0.5mL – 0.5mL pre-filled syringe ***[≥ 9 years old]***	☐ **FLUZONE High-Dose (TIV)®** – DIN 0242 0643 – TIV 60mcg/0.5mL – 0.5mL pre-filled syringe ***[≥ 65 years old]***

Dose: 0.5 mL	Route: IM	Vaccine Lot #:	Vaccine Expiry (MM/YYYY):

Site of administration: ☐ Left deltoid ☐ Right deltoid ☐ Other _____ | Time of Immunization:

PHARMACIST DECLARATION: I confirm the above-named patient/parent is capable of providing consent for seasonal influenza vaccine, that the seasonal influenza vaccine should be administered to the patient, and that I have administered the seasonal influenza vaccine to the patient as indicated on this form.

Pharmacist Signature:	OCP License #	Date Signed (DD/MM/YYYY)