Pharmacy 101
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:		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.

Please answer the following 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: ☐ Sore throat ☐ Nasal congestion ☐ Headache ☐ Runny nose/sneezing ☐ Chills ☐ Difficulty swallowing ☐ Hoarse voice ☐ Unexplained diarrhea ☐ Decreased or loss of sense of smell ☐ Unexplained fatigue/malaise ☐ Abdominal pain or nausea/vomiting			☐ None of the listed symptoms	
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: ☐ Kanamycin ☐ Gentamicin ☐ Neomycin ☐ Thimerosal ☐ Chicken 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 severe reaction to **eggs or egg products**? (e.g. wheezing, chest tightness, difficulty breathing, hives)	☐	☐	☐	
Have you had a reaction to **eggs or egg products** but can still eat small amounts of egg? (e.g. stomach ache)	☐	☐	☐	If *YES*, or *UNSURE*, you can receive the flu shot, but **MUST BE OBSERVED FOR 30 MINUTES AFTERWARDS**

Pharmacy101
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 2: Screening Questionnaire (continued)				
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
Do you have a **new or changing** neurological disorder?	☐	☐	☐	If *YES*, do **NOT** get the shot & see 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 / Agent Name (& Relationship)	Patient / Agent **Signature**	Date Signed (DD/MM/YYYY)

Section 4: Prescription Templates – Pharmacy Use Only

Site of administration: ☐ Left deltoid ☐ Right deltoid	Date of Immunization (DD/MM/YYYY):	Time of Immunization:

PHARMACIST DECLARATION: I can confirm the above named patient is capable of providing consent for seasonal influenza vaccine and that I have administered the seasonal influenza vaccine as indicated on this form.

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