LEEDS PHARMACY
163 Ormond st, Brockville, ON
Tel 613-865-8885
WWW.Leedspharmacy.ca

Flu Vaccine Consent Form

Patient Information		
First Name:	**Last Name:**	
Date of Birth: (dd / mm / yyyy):		**Age:**
Address:		
Health Card #:	**Telephone Number:**	
Emergency Contact Name and Telephone Number:		

Screening Questionnaire for Person to be Vaccinated	Yes	No
Do you or have you had a fever within the past 3 days? (i.e., fever greater than 38.0°C, breathing problems, active infection)?		
Have you had a serious reaction to influenza vaccine in the past?		
Do you have any allergies, including allergy to eggs or egg products?		
Do you have an allergy to any of the components of the flu vaccine? *(e.g., gentamicin, neomycin, kanamycin, Polymyxin, thimerosal, formaldehyde)*		
Do you take a blood thinner or have a bleeding disorder?		
Do you have a new or changing condition affecting the brain or nervous system?		
Have you ever had Guillain-Barré syndome?		
If patient is a child less than 9 years old, are they receiving Influenza vaccine for the first time?		
Are you pregnant?		

Seasonal Inactivated Influenza Vaccination Patient/Agent Consent:

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the Fact Sheet. I have had a 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.
- ❑ If your child is less than 9 years of age, and getting the influenza vaccine for the first time, your child will need 2 doses of vaccine this season. They are given at least 4 weeks apart.

Name : _____ Signature _____ Date: _____

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Immunization Record

Patient Name :

Date of administration: / /	**Time of administration:** AM / PM

Pharmacist Documentation - Pharmacy use only

☐ **Fluzone®QIV Vial ++** **DIN: 02432730** **For 6 months old and older** **Dose: 0.5 ml Route: IM**	☐ **Fluzone®QIV Syringe** **DIN: 02420643** **For 6 months old and older** **Dose: 0.5 ml Route: IM**	☐ **AFLURIA TET Vial */++** **DIN: 02473313** **For 5 years old and older** **Dose: 0.5 ml Route: IM**	☐ **AFLURIA TET Syringe*** **DIN: 02473283** **For 5 years old and older** **Dose: 0.5 ml Route: IM**
☐ **FluLaval Tetra** **DIN: 02420783** **For 6 months old and older** **Dose: 0.5 ml Route: IM**	☐ **Fluzone® QIV High-Dose** **DIN: 02500523** **seniors 65 years +** **Dose: 0.7 ml Route: IM**	☐ **FLUAD Syringe*** **DIN: 02362384** **seniors 65 years +** **Dose: 0.5 ml Route: IM**	☐ **DIN:** **Dose: ml Route: IM**
Site: Deltoid ☐ **Left** ☐ **Right**	**Lot #:**		**Expiry:**

I confirm that the patient named above is capable of providing consent for the seasonal influenza vaccination or that a parent/ guardian or other agent has provided consent on behalf of the patient. I confirm that the seasonal influenza vaccine should be given to the patient based on my assessment.

Administration is done by: :

☐ Tamer Badawy OCP Lic #: 605149

☐ Threse Guirguis OCP. Lic# 615717

☐ Bridget Graham OCP Lic# 625841

Signature _____ Date: _____

* Contains antibiotics ++ Contains Thiomersal