ST. ALBERT PEOPLES PHARMACY

INFLUENZA AND COVID VACCINATION SCREENING AND CONSENT FORM

Client: _____ ☐Male ☐ Female
First Name Last Name

Date of Birth: _____ Alberta Health #: _____ Phone Number: _____

Address: _____ Emergency Contact: _____

E mail:

Pre-vaccination Questions	**Yes**	**No**
In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing, sore throat, runny nose, feeling unwell?		
Have you ever had a reaction to any immunization previously (eg. hives, fainting, difficulty breathing)?		
Do you have allergies to medications, food (eg. eggs), vaccine components or latex?		
Do you take any medications that suppress your immune system or are you immunocompromised?		
Do you take a blood thinner or have a bleeding disorder?		
Have you had Guillain Barre Syndrome within 6 weeks of getting a flu shot?		
Do you have a history of Oculo-Respiratory Syndrome?		
Are you pregnant, nursing, or do you intend to become pregnant?		
If patient is a child less than 9 years old, are they receiving the Influenza vaccine for the first time?		
Have you received Shingles vaccine? ☐Yes ☐ No Pneumonia vaccine? ☐Yes ☐ No		
Have you ever had a COVID-19 infection? If yes, please indicate when it was resolved:		
Have you received a previous dose of COVID-19 vaccine? If yes, please specify: _____ Most recent dose date: _____		

I, the undersigned patient, parent or guardian, have read or have had explained to me information about the vaccine. 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.

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.

Name (Client or Responsible Party) – Please Print _____ Signature (Client or Responsible Party) _____ Date _____

Pharmacy Use Only

Influenza Vaccine	Covid Vaccine
Vaccine Lot #:	Vaccine Lot #:
Expiry Date:	Expiry Date:
Route: **IM** Site:	Route: **IM** Site:
Date and Time:	Date and Time:

Administering Pharmacist Name (Print):	Signature: