2020-2021 Seasonal Influenza (Flu) Vaccine Consent Form

Section 1: Patient Information

Date (MM/DD/YYYY):				
Last Name:	First Name:	Prov. Health Number:	Gender:	
Main Phone Number:	Alternate Phone Number:	Date of Birth (MM/DD/YYYY):	Age:	Child's weight: (kg / lb)
Address:	City:	Province:	Postal Code:	
Emergency Contact's Last Name:	Emergency Contact's First Name:	Relationship:	Emergency Contact's Main Phone Number:	
Emergency Contact's Alternate Phone Number:		Ask your pharmacist about age restriction for flu shots in a pharmacy		

Section 2: Screening Questionnaire Refer to Screening Questionnaire Action Guide for recommendations

	Yes	No
Are you, or have you been **sick within the past 3 days**? (fever greater than 39.5°C, breathing problems, or active infection)		
Have you had difficulty breathing, wheezing or chest tightness within 24 hours of getting an **influenza vaccine**?		
Are you **allergic** to any part of the influenza vaccine, or have you had a severe, life-threatening allergic reaction to a past influenza vaccine?		
Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to: • **Contact lens solution** • **Egg or egg products** • **Formaldehyde** • **Gelatin** • **Gentamicin** • **Kanamycin** • **Neomycin** •**Thimerosal**•**Polymyxin B**		
Do you have a serious allergy to **latex** or **natural rubber**?		
Have you had a reaction to **eggs** or **egg products** but can still eat small amounts of egg? (eg. Stomach ache, skin reaction)		
Have you had **Guillian-Barré Syndrome** within 6 weeks of getting an influenza vaccine? **Oculo-Respiratory Syndrome**?		
Have you ever had a **seizure** or have an active, new, or changing **neurological disorder**?		
Do you have **bleeding problems** or use **blood thinners**? (eg. Warfarin)		
Are you **pregnant**, **nursing**, or do you **intend to become pregnant**?		
Have you received your pneumonia vaccines? If yes, which vaccine_____and when:_____		
Have you received your shingles vaccines? If yes, which vaccine and when:		
Only fill this section if planning to receive the nasal influenza vaccination — 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 asthma** (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. Oseltamivir)?		
Do you have any medical conditions (eg. Cancer, leukemia, HIV/AIDS) or take 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 allergic (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 clinic/pharmacy for 15 minutes (or the time recommended by the pharmacist).

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.

☐ 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

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 begiven 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.

Trivalent Influenza Vaccine (TIV):	☐ **AGRIFLU®** 0.5 mL IM DIN 02346850	☐ **FLUAD®** 0.5 mL IM DIN 02362384	☐ **FLUAD Pediatric®** 0.25 mL IM DIN 02434881	☐ **FLUVIRAL®** 0.5 mL IM DIN 02420686	☐ **FLUZONE High-Dose®** 0.5 mL IM DIN 02445646	☐ **INFLUVAC®** 0.5 mL IM DIN 02269562

☐ **FLULAVAL™ TETRA** 0.5mL IM DIN 02420783	**AFLURIA® TETRA** ☐ 0.5mL IM pre-filled syringe DIN 02473283 ☐ 5mL IM multi-dose vial DIN 02473313	**FLUZONE® QUADRIVALENT** ☐ 0.5mL IM single-dose vial DIN 02420643 ☐ 5mL IM multi-dose vial DIN 02432730	☐ **INFLUVAC® TETRA** 0.5mL IM DIN 02484854	☐ **Live Attenuated Influenza Vaccine (LAIV): FLUMIST®** 0.1mL per nostril (0.2mL total dose intra-nasally) DIN 02426544

Date of Immunization (MM/DD/YYYY):	Time of Immunization:	Vaccine Lot #:	Vaccine Expiry (MM/YYYY):	Health Care Provider's Name & License #:	Signature:

Site of Administration: ☐ Left Arm ☐ Right Arm ☐ Intranasal		Contacted Primary Prescriber: ☐ Yes ☐ No	Emergency Treatment: ☐ Yes (see attached) ☐ No
NS Only	Patient condition before:	Response during:	Response immediately after:

Epinephrine Emergency Treatment

Patient's Last Name:	Patient's First Name:	Patient's Date of Birth (MM/DD/YYYY):
☐ EpiPen® 0.3mg/0.3mL DIN 00509558 If weight is >30kg or 66 lbs	☐ EpiPen® Junior 0.15mg/0.3mL DIN 00578657 If weight is between 15-30kg or 33-66 lbs	
Date of Administration (MM/DD/YYYY):	Times of Administration 1. 2. (if applicable) 3. (if applicable)	
Number of Doses Administered:		
Health Care Provider's Name & License #:	Signature:	
Additional Notes (including other emergency measures taken or treatments administered):	Date (MM/DD/YYYY) & Time of Follow-up with Patient/Agent:	