INFLUENZA VACCINE SCREENING FORM

WAY STREET PHARMACY

SURNAME _____ **FIRST NAME** _____ **DATE OF BIRTH** _____

EMAIL _____ **PHONE NUMBER** _____ **HEALTH CARD NUMBER** _____

ADDRESS (STREET) _____ **CITY/TOWN** _____ **PROV.** _____ **POSTAL CODE** _____

EMERGENCY CONTACT NAME _____ **EMERGENCY CONTACT PHONE #** _____ **EMERGENCY CONTACT RELATIONSHIP** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS (MUST BE COMPLETED BY A PARENT OR GUARDIAN IF UNDER 16)

☐ Yes ☐ No Have you had a high fever or temperature in the last 24 hours

☐ Yes ☐ No Have you ever had an allergic or anaphylactic reaction to an influenza vaccine or any other vaccine before?
If yes, please describe the reaction:

☐ Yes ☐ No Have you ever suffered from severe stress, or have fainted when receiving a vaccine?

☐ Yes ☐ No Have you ever developed Guillain-Barre syndrome within 6 weeks of receiving a vaccine?
(Guillain-Barre syndrome is an immune system disorder in which nerves are attacked by immune cells and cause weakness and tingling in arms and legs.)

☐ Yes ☐ No Do you have an allergy to any of the following components of the flu vaccine (please check all that apply):

☐ Eggs ☐ Latex ☐ Thimerosal ☐ Neomycin ☐ Kanamycin ☐ Gentamicin

☐ Yes ☐ No Have you ever suffered from a severe asthma attack or had difficulty breathing?

☐ Yes ☐ No Do you have a bleeding disorder, or do you take any medication that thins your blood (☐ anticoagulants or ☐ salicylates)?

☐ Yes ☐ No Are you immunocompromised due to disease or treatment (eg. prednisone, chemotherapy, radiotherapy) ? If yes, please provide details.

☐ Yes ☐ No Are you likely to come in contact with a severely immunocompromised person?

For women only

☐ Yes ☐ No Are you currently breastfeeding?

☐ Yes ☐ No Are you pregnant, or is there any chance you are pregnant?

COVID 19 SCREENING

☐ Yes ☐ No Do you have any of the following symptoms: runny nose, nasal congestion, sore throat, difficulty swallowing, chills, headache, new onset fatigue, new onset muscle pain, nausea, vomiting, diarrhea, pink eye, loss of taste or smell?

☐ Yes ☐ No Do you feel unwell today, have a fever (above 39.5C) or a cough, shortness of breath or difficulty breathing?

☐ Yes ☐ No Have you been in contact with someone who has tested positive for Covid-19 during the past 14 days?

DECLARATION (Please initial in the spaces provided)

My pharmacist has reviewed with me the benefits, side effects and risks associated with the influenza vaccine being administered today and gave me the opportunity to ask questions, address my concerns and seek clarification about the vaccine being administered. _____

I agree to remain / keep my dependent at the pharmacy for at least 15 minutes following administration of the vaccine, or as directed by the pharmacist. _____

In the event of a severe reaction, I authorize my pharmacist to administer an EpiPen, a salbutamol (Ventolin) inhaler, diphenhydramine (Benedryl) as necessary. _____

In case of emergency, I authorize the pharmacist to administer CPR, contact EMS, and notify the emergency contact listed on this form. _____

☐ **I consent to receiving the vaccine today.**

☐ **I authorize the pharmacist to administer the vaccine to my child/dependent today.**

_____ _____
Name (print) Signature

TO BE COMPLETED BY A PHARMACIST
ATTACH VACCINE INFORMATION STICKER

Date of vaccination: _____ Time: _____ Dose: _____ mL

Route ☐ I.M. ☐ Left Deltoid ☐ Right Deltoid ☐ Oral ☐ Nasal

ADR: ☐ No ☐ Yes _____

Is follow-up required? ☐ No ☐ Yes

Follow-up plan: _____

_____ _____
Pharmacist Name & OCP# Signature