

# 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 <u>Screening Questionnaire Action Guide</u> for recommendations		Yes	No
Are you, or have you been <b>sick within the past 3 days?</b> (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 <b>influenza vaccine?</b>			
Are you <b>allergic</b> 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: <b>• Contact lens solution • Egg or egg products • Formaldehyde • Gelatin • Gentamicin • Kanamycin • Neomycin • Thimerosal • Polymyxin B</b>			
Do you have a serious allergy to <b>latex</b> or <b>natural rubber?</b>			
Have you had a reaction to <b>eggs</b> or <b>egg products</b> but can still eat small amounts of egg? (eg. Stomach ache, skin reaction)			
Have you had <b>Guillian-Barré Syndrome</b> within 6 weeks of getting an influenza vaccine? <b>Oculo-Respiratory Syndrome?</b>			
Have you ever had a <b>seizure</b> or have an active, new, or changing <b>neurological disorder?</b>			
Do you have <b>bleeding problems</b> or use <b>blood thinners?</b> (eg. Warfarin)			
Are you <b>pregnant, nursing,</b> or do you <b>intend to become pregnant?</b>			
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 <b>vaccines</b> in the last 4 weeks?		
	For children under 18 years old: Is the child using, or will be using an <b>aspirin/aspirin-containing therapy</b> in the next 4 weeks?		
	Do you have <b>severe asthma</b> (on high dose inhaled or oral corticosteroids) or medically attended <b>wheezing</b> in the past 7 days?		
	Have you received in the past 48 hours or do you intend to receive in the next 2 weeks <b>flu antiviral therapy?</b> (eg. Oseltamivir)?		
	Do you have any medical conditions (eg. Cancer, leukemia, HIV/AIDS) or take medications that weaken the <b>immune system?</b>		
	Do you provide health care services to or do you have close contact with persons who are <b>immunocompromised?</b>		
	Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to Arginine?		

Section 3: Consent Given By Patient/Agent		
<p>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).</p> <p>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.</p>		
<input type="checkbox"/> I confirm that I want to receive the seasonal influenza vaccine <b>OR</b> <input type="checkbox"/> 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						
<b>HEALTH CARE PROVIDER'S DECLARATION:</b>						
<input type="checkbox"/> I confirm the above named patient is capable of providing consent for the seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient. I am administering the seasonal influenza vaccine no more than <u>21 days</u> after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient.						
<input type="checkbox"/> <b>AGRIFLU®</b> 0.5 mL IM DIN 02346850	<input type="checkbox"/> <b>FLUAD Pediatric®</b> 0.25 mL IM DIN 02434881	<input type="checkbox"/> <b>FLUAD®</b> 0.5 mL IM DIN 02362384	<input type="checkbox"/> <b>INFLUVAC®</b> 0.5 mL IM DIN 02269562	<input type="checkbox"/> <b>FLUVIRAL®</b> 0.5 mL IM DIN 02420686	<input type="checkbox"/> <b>FLUZONE High-Dose®</b> 0.5 mL IM DIN 02445646	<input type="checkbox"/> <b>FLUMIST®</b> 0.1mL per nostril DIN 02426544
<input type="checkbox"/> <b>FLULAVAL® TETRA</b> 0.5mL IM DIN 02420783	<input type="checkbox"/> <b>AFLURIA® TETRA</b> <input type="checkbox"/> 0.5mL IM pre-filled syringe DIN 02473283 <input type="checkbox"/> 5mL IM multi-dose vial DIN 02473313	<input type="checkbox"/> <b>FLUCELVAX® QUAD</b> <input type="checkbox"/> 0.5mL IM pre-filled syringe DIN 02494248 <input type="checkbox"/> 5mL IM multi-dose vial DIN 02494256	<input type="checkbox"/> <b>FLUZONE® QUAD</b> <input type="checkbox"/> 0.5mL IM single-dose vial DIN 02420643 <input type="checkbox"/> 5mL IM multi-dose vial DIN 02432730	<input type="checkbox"/> <b>INFLUVAC® TETRA</b> 0.5mL IM DIN 02484854	<input type="checkbox"/> <b>OTHER</b>	
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: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Intranasal		Contacted Primary Prescriber: <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency Treatment: <input type="checkbox"/> Yes (see attached) <input type="checkbox"/> No		
NS Only	Patient condition before:	Response during:		Response immediately after:		

## Epinephrine Emergency Treatment

Pharmacy Name:		Pharmacy Address:	
Patient's Last Name:	Patient's First Name:	Patient's Date of Birth (MM/DD/YYYY):	
<input type="checkbox"/> EpiPen® 0.3mg/0.3mL DIN 00509558   PIN 09857423 If weight is >30kg or 66 lbs Expiry date: _____ Lot Number: _____		<input type="checkbox"/> EpiPen® Junior 0.15mg/0.3mL DIN 00578657   PIN 09857424 If weight is between 15-30kg or 33-66 lbs Expiry date: _____ Lot Number: _____	
Date of Administration (MM/DD/YYYY):		Times of Administration	
Number of Doses Administered:		1.	
		2. (if applicable)	
		3. (if applicable)	
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:	
<b><u>Nova Scotia ONLY:</u></b>			
Patient condition before:	Response during:	Response immediately after:	
<b><u>Ontario ONLY:</u></b> Please attach a copy of the completed flu consent form to be compliant with the documentation requirements set by the Ontario College of Pharmacists			