Consent For Influenza Vaccine Immunization

❶ Patient Information

Complete sections 1, 2 and 3 (Please Print)

Last Name: First Name: Gender: Birth Date (YYYY-MM-DD):

Address: Phone #:

Emergency contact name: Emergency contact phone #:

Doctor's name: Doctor's phone #:

Canadian resident: ☐ No ☐ Yes Personal Health Number: Child's weight (kg): Pregnant/Breastfeeding: ☐ No ☐ Yes ☐ N/A

As a precaution to limit further transmission of COVID-19, please answer:

1. Do you have a new onset of: ☐ fever or chills ☐ cough ☐ shortness of breath or difficulty breathing ☐ fatigue ☐ muscle or body aches ☐ headache ☐ loss of taste or smell ☐ sore throat ☐ congestion or runny nose ☐ nausea or vomiting ☐ diarrhea ☐ No, not applicable
2. Have you been in contact with a confirmed or probable case of COVID-19 in the past 14 days? ☐ No ☐ Yes
3. Have you traveled outside of Canada in the past 14 days? ☐ No ☐ Yes
4. Have you been presently instructed to self-isolate/quarantine by local public health authorities due to travel or contact history? ☐ No ☐ Yes

❷ Health Information

- Have you ever had an influenza vaccine immunization before? ☐ No ☐ Yes
- Do you have a fever, infection or feel unwell today? ☐ No ☐ Yes, please describe: ____________________
- Have you ever fainted or had a serious reaction (e.g. Guillain-Barre Syndrome) to any previous injection or vaccine? ☐ No ☐ Yes, please specify: ____________________
- Do you have any medication, food or other known allergies? ☐ No ☐ Yes, please list: ____________________
- Is your immune system affected by any condition or medication? ☐ No ☐ Yes, please specify: ____________________
- Are you on any medications? ☐ No ☐ Yes, please list: ____________________

❸ Consent

☐ Patient ☐ Parent ☐ Legal guardian ☐ Representative

- I consent to receiving/for my child to receive the influenza vaccine.
- I understand the benefits, possible common side effects and risks of receiving the influenza vaccine (collectively, the "Risks"), and I waive any claim for any direct or indirect liability or loss that I (or anyone claiming on my behalf) may have against London Drugs and its directors, officers, employees and the administering personnel for such Risks.
- I have had the opportunity to ask questions that were answered to my satisfaction.
- I agree to stay in the pharmacy/clinic area for at least 15 minutes after receiving the influenza vaccine and to immediately notify the pharmacist of any adverse reaction.
- I authorize the pharmacist to administer epinephrine and/or life-saving measures in the event of a severe allergic reaction or emergency.
- I consent for the information collected on this form 1) to be provided to my family doctor and to the health authority for entry into my immunization record, and 2) to be used and disclosed by London Drugs and its nurses, pharmacists, pharmacy employees and medical advisors for the purposes of providing health care services or otherwise as authorized or required by applicable laws.

Initial: ______ I consent to blood testing for blood-borne infections such as Hepatitis B, Hepatitis C and HIV in the event that a health care worker or another individual is exposed to my blood or bodily fluids.

Initial: ______ I consent to the disclosure of my test results for blood-borne infections such as Hepatitis B, Hepatitis C and HIV to a health care provider for the purpose of providing care to an individual who has been exposed to my blood or bodily fluids.

Having read, understood and agreed with all the terms of this document, I hereby agree to same by signing where indicated below.

Name (Print): ____________________ Signature: ____________________ Date (YYYY-MM-DD): ____________________

Provincial law, pharmacy age limits and other restrictions may apply to determine eligibility to receive injection. The administering staff may refuse to administer the injection to any person in his/her sole discretion.

FOR PHARMACIST USE ONLY

❹ Vaccine Information

Vaccine name: ____________________ DIN: ______________ Dose: ______mL Site: ☐ LA / ☐ RA Route: ☐ IM / ☐ Other: ____________________

Lot #: ____________________ Expiry (YYYY-MM-DD): ____________________ Injection fee: $_________ LA left arm; RA right arm; IM intramuscular

❺ Pharmacist Information

Pharmacist name: ____________________ Signature: ____________________ License #: ____________________

Date of administration (YYYY-MM-DD): ____________________ Time of administration: ______________

❻ Patient Response

15-30 min post-administration: Normal ☐ Yes ☐ No, please specify: ____________________

Other comments: ____________________

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