Rexall™ FluShot

Patient Consent for Flu (Influenza) Immunization

By provincial legislation, Pharmacists cannot administer a flu shot to children under a certain age. Ask your pharmacist for age restrictions.

Name:			Provincial Health Number:
Gender:		Email :	
Date of Birth (MM/DD/YYYY):	Age:	Pregnant: ☐ Yes ☐ No ☐ N/A	Patient Phone:
Address:			Child's Weight: kg or lb
Emergency Contact Name:			Contact Phone:
Relationship to Patient:			
Family Physician Name:			Physician Phone:

Injection Screening Questionnaire

	Yes	No
1. 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?	☐	☐
2. Have you ever had a reaction to any immunizations previously?	☐	☐
3. Do you have allergies to medications, food (e.g. eggs), vaccine components, or latex?	☐	☐
4. Do you have any heart, lung, or diabetic condition?	☐	☐
5. Have you had close contact with anyone with a severely weakened immune system?	☐	☐
6. Do you have a history of Oculo-Respiratory Syndrome?	☐	☐
7. Do you have a history of Guillain-Barre Syndrome within 6 weeks of getting a flu shot or had difficulty breathing within 24 hours of getting a flu shot?	☐	☐
8. Have you received a full COVID-19 vaccine course? If no, when was your last dose?"	☐	☐
9. Have you received your Shingles vaccines?	☐	☐
10. Have you received your Pneumonia Vaccine?	☐	☐

Are you currently taking any of the following prescription medications?

	Yes	No		Yes	No
Prednisone or other immunosuppressants	☐	☐	Antiviral Drugs	☐	☐
Drugs for rheumatoid arthritis, Crohn's disease or psoriasis	☐	☐	Other (Specify):	☐	☐

Note: If you answered **YES** to any of the above questions, the Pharmacist will ask you further questions. Pending your response, you may not be eligible to receive an influenza vaccine today.

Consent Given By Patient/Agent

I, the undersigned patient, parent or guardian, have read or had explained to me information about the vaccine as outlined on the vaccine monograph. 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. I understand and agree that I may be asked to wait in the clinic/pharmacy for 15-20 minutes after getting the flu shot.

☐ 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/Guardian Name:

Patient/Guardian Signature:

☐ Patient verbal consent provided (excludes ON)

Pharmacy Use Only

Vaccine Name:
☐ AGRIFLU® ☐ VAXIGRIP® ☐ INTANZA® ☐ FLUAD® ☐ FLUZONE® HD
☐ FLULAVAL® ☐ FLUZONE QIV® ☐ FLUVIRAL® ☐ INFLUVAC® ☐ AFLURIA TETRA®
☐ FLUMIST® ☐ FLUCELVAX® QUAD ☐ Other: _____

Date of Vaccine: Time of Vaccine: Vaccine Lot#:

Dose: Expiry:

Route: ☐ IM ☐ SC ☐ NAS Site: ☐ Left Arm ☐ Right Arm

AB ONLY

☐ (46) Pregnant
☐ (2) 65+
☐ (68) 5-64 Chronic/ High Risk
☐ (39) Household High Risk
☐ (69) 5- 64 NOT High Risk

SK ONLY

☐ On-site
☐ Off-site
☐ 5-8 (2 fees/yr. – 1st time)
☐ Personal care homes 65+

Additional Notes (including emergency measures taken or patient follow-up):

Child between the ages of 6 months to less than 9 years getting vaccinated for 1st time: Yes ☐ No ☐
If Yes, schedule 2nd flu shot in 28 days
Date: _____

PHARMACIST'S DECLARATION: I confirm that I have communicated the risks and benefits associated with the vaccine. I have reviewed the patient record and find that the vaccine should be given to the patient.

Pharmacist Name:	License #:	Date:
Pharmacist Signature:		