Injectable Vaccine Screening Tool and Consent Form

Patient information	
Name: (Last, First)	**Date of birth (YYYY-MM-DD)**
Address:	
Health Services Number:	**Gender: M / F** **Weight:**
Daytime Phone Number:	**Alternate Phone Number:**
Emergency Contact Information **Name:**	**Phone Number:**

Screening: The following questions will help determine if a vaccine is right for you today. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist should be aware of it and may have some additional questions for you.

Do you (or your child / dependent):

1. Feel sick today?	☐ Yes	☐ No
2. Have allergies to medications, food, a vaccine component, or latex?	☐ Yes	☐ No
3. Have a history of serious reaction after receiving a vaccination?	☐ Yes	☐ No
4. Have any of the following medical conditions: **☐ bleeding problems** **☐ asthma** **☐ cancer, HIV/AIDS or other immune system disorders**		
5. Take any of the following medications (currently, recently): **☐ blood thinners (aspirin, warfarin)** **☐ drugs used to treat immune system disorders such as prednisone, other steroids, or anticancer drugs** **☐ drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis** **☐ antiviral drugs**		
6. Require a TB skin test within next 4 weeks? Have a history of a positive TB skin test?	☐ Yes	☐ No
7. Have close contact with anyone with a severely weakened immune system?	☐ Yes	☐ No
8. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐ Yes	☐ No
9. Have a history of any vaccinations in the past 4 weeks?	☐ Yes	☐ No
10. During the past year, have a history of receiving a transfusion of blood or blood products, or immune (gamma) globulin?	☐ Yes	☐ No

Q1-5 Injectable inactivated influenza vaccine **Q1-8 Live attenuated influenza vaccine** **Q1-10 Other vaccines**

Declaration of Consent:

I confirm that I have read or had explained to me the attached vaccine information sheet regarding the risks, benefits and potential side effects associated with the vaccine. I have had the opportunity to have my questions answered by the pharmacist and am satisfied with and understand the information I have been given. I consent to receiving or my child /dependent receiving this vaccine.

_____ _____

Signature of: ☐ Vaccine recipient ☐ Parent /guardian ☐ Proxy **Date**

For Pharmacist Use Only

Drug/Vaccine: Name, DIN, Lot #, Expiry Date	Dose	Site	Route	Dose #	Pharmacist Signature	Date &Time of Injection
		LA RA Other:	IM SC IN			

Adverse reaction: ☐ No ☐ Yes – describe reaction: **Cost:**

☐ Notified primary care practitioner (if applicable): Name_____ Fax #:_____
☐ Reported immunization to electronic provincial registry (if applicable)
☐ If first influenza vaccination, age 5 to less than 9 years, appointment date for 2nd injection: _____
(minimum interval of 4 weeks between injections)