INFLUENZA VACCINATION PATIENT SCREENING AND CONSENT

Patient Name: _____ DOB (YYYY/MON/DD): _____ Age: _____

Gender: _____ Weight (If under 12 years of age): _____

Health Card Number: _____

Address: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

As of today, Respiratory Illness Screening	Yes	No
Do you feel unwell today, have a fever (above 39.5°C) or a cough (new or worsening), shortness of breath or difficulty breathing?		
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?		
As of today, Pre-Immunization Assessment	**Yes**	**No**
Is this the first time you are receiving an influenza vaccine? If you are under 9 years of age and have never received an influenza vaccine, then you require two doses 28 days apart.		
If you are under age 5, have you received a Covid-19 vaccination in the last 14 days? Please provide the date you received the vaccine _____ (YYYY/MON/DD) and book your influenza vaccine 14 days later.		
Have you ever fainted following a previous vaccination? If yes, please inform your immunizer.		
Have you ever had a serious reaction (including anaphylaxis) to any previous injection or vaccine(s)? If yes, please describe the reaction: _____ The person receiving the vaccine may be immunized; due to the history of serious reaction, they will be observed 30 minutes after receipt of the vaccine.		
Have you ever developed Guillain-Barré Syndrome within 6 weeks of receiving an influenza vaccine?		
Do you have an allergy to any of the following? Please check all that apply: ❑ Latex ❑ Thimerosal ❑ Formaldehyde ❑ Triton® X-100 ❑ Neomycin ❑ Kanamycin ❑ Gentamicin ❑ Polysorbate 80 ❑ CTAB (Cetyltrimethylammonium Bromide) ❑ Sodium Deoxycholate ❑ Sucrose If you indicated yes to any boxes, please discuss with immunizer.		
Do you have any allergies to any other medications, foods or products? If yes, please list: _____ Please discuss with immunizer, you may need to be observed 30 minutes after receiving the vaccination.		
Do you have a bleeding condition or use any blood thinners (i.e. Warfarin, low or high dose aspirin)?		
Are you pregnant?		
Have you ever had a mastectomy with lymph node removal? If yes, please indicate which side: ❑ Left ❑ Right		

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- My immunizer has reviewed with me the benefits, side effects and risks (including risks of not receiving vaccine) associated with the influenza vaccine being administered today.
- I have had the opportunity to have my questions answered.
- I/my dependent, agree to remain at the immunization clinic for at least 15-30 minutes following administration of the medications/vaccine or as directed by the immunizer.
- I authorize my immunizer to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction and to notify my emergency contact person.
- I authorize my immunizer to notify my physician/nurse practitioner and/or public health of the vaccine received and to contact me with any follow-up if needed.

❑ **I consent to receive the influenza vaccine today**

❑ **I consent for my child/dependent to receive the influenza vaccine today**

Name: _____ Signature: _____
(Print) (Guardian/Agent as required)

Date (YYYY/MON/DD): _____

INJECTION ADMINISTRATION DOCUMENTATION

❑ **Fluzone® MDV** ❑ **Fluzone® PFS** ❑ **FLUAD® (all clients 65 and older)** ❑ **FluLaval Tetra**	❑ **Afluria MDV (greater than 5 years of age)** ❑ **Other:** _____	
Dose:	**Lot:**	**Expiry** (YYYY/MON/DD):
Route: ❑ IM **Site:** *Deltoid:* ❑ Left ❑ Right *Vastus Lateralis:* ❑ Left ❑ Right **Date** (YYYY/MON/DD): _____ **Time:** _____ (HH:MM)		

PATIENT MONITORING AND FOLLOW UP

15-30 minutes post injection: ❑ Patient appears fine, no adverse reaction(s)

Comments:

Clinic Location: _____ **Phone:** _____

Immunizer Name (print): _____

License #: _____ **Signature:** _____

Communication to other Health Care Providers (physician, nurse practitioner, public health) via: ❑ **Fax** ❑ **DIS**