# Vaccine Screening Tool and Consent Form

| Patient information: | |
|---|---|
| **Name: (Last, First)** | **Date of birth (DD-MM-YYYY):** |
| **Address:** | |
| **Health Services Number:** | **Gender: M / F** **Weight:** |
| **Daytime Phone Number:** | **Alternate Phone Number:** |
| **Emergency Contact Information**<br>**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 (check all that apply):**<br>☐ bleeding problems<br>☐ brain or nervous system disorders (e.g. seizures)<br>☐ asthma<br>☐ cancer, HIV/AIDS or other immune system disorders | | |
| **5. Take any of the following medications (check all that apply):**<br>☐ blood thinners (e.g. aspirin, warfarin)<br>☐ drugs used to treat immune system disorders such as prednisone, other steroids, or anticancer drugs<br>☐ drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis<br>☐ antiviral drug | | |
| **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, inhaled** **Q1-10 Other vaccines**

**Declaration of Consent:**

**I confirm that I have read or had explained to me the risks, benefits and potential side effects associated with _____ (drug name). My questions have been answered by the pharmacist and I am satisfied with and understand the information I have been given. I consent to receiving or my child /dependent receiving this injection, and understand the requirement for post-injection observation by the pharmacist for 15 minutes.**

***Note:** **An individual's health information may be shared with another healthcare provider as necessary for their care.***

_____ _____

**Signature of:** ☐ **Injection recipient** ☐ **Parent /guardian** **Date**

**For Pharmacist Use Only:**

| Vaccine: Name, DIN, Lot #, Expiry Date | Dose | Site | Route | Dose# | Pharmacist Signature | Date &Time of Injection |
|---|---|---|---|---|---|---|
| | | LA<br>RA<br>Other: | IM<br>SC<br>ID | | | |

**Adverse reaction:** ☐ **No** ☐ **Yes – describe reaction:** **Price, if applicable:**

☐ **Notified primary care practitioner (if applicable) Name:** _____ **Fax #:**_____

☐ **Reported immunization to electronic provincial registry, if applicable** ☐ **Discussed publically funded options, if applicable**

***Please refer to product monograph for administration instructions. Ensure patient medication profile checked prior to injection.***