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 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):

Question	Yes	No
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): ☐ bleeding problems ☐ brain or nervous system disorders (e.g. seizures) ☐ asthma ☐ cancer, HIV/AIDS or other immune system disorders		
5. Take any of the following medications (check all that apply): ☐ blood thinners (e.g. 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 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, inhale 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 this vaccination. 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.

____________________________________ ________________________ ______

Signature of: ☐ Vaccine Recipient ☐ Parent /guardian ☐ Proxy Date

For Pharmacist Use Only:

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

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

☐ Notified primary care practitioner (if applicable) Name: ________________________ Fax #:______________________

☐ Reported immunization to electronic provincial registry (if applicable)

☐ Discussed publically funded options (if applicable)

☐ If first influenza vaccination, age 5 to less than 9 years old, appointment date for 2nd injection: ________________________
(minimum interval of 4 weeks between injections)