Vaccine Screening and Consent Form
(All Vaccines)

VACCINE RECIPIENT INFORMATION

Name: (Last, First)	Date of Birth:	Age:
Address:	Health Services Number:	
Phone Number:	Sex: ◯ Male ◯ Female ◯ Other	
EMERGENCY CONTACT Name:	Phone Number:	

SCREENING

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

1. Do you **feel sick today**?	◯ Yes	◯ No
2. Do you have **severe allergies** to **medications, food,** a **vaccine component** or **latex**? If yes, please describe:	◯ Yes	◯ No
3. Have you ever had a **serious reaction after receiving a vaccination**? If yes, please describe:	◯ Yes	◯ No
4. Do you have any of the following **medical conditions**: ◯ **Bleeding problems** ◯ **Asthma** ◯ **Lymphatic circulation impairment** (e.g. lymphedema, axillary lymph node removal [mastectomy, lumpectomy], amputation) ◯ **Autoimmune disorder**? (e.g.: Crohn's disease, lupus, multiple sclerosis, psoriasis, rheumatoid arthritis, type 1 diabetes) ◯ **Cancer, HIV infection, Transplant, Other immune system disorders**	◯ Yes	◯ No
5. Do you **take any of the following medications** (currently, recently): ◯ **Blood thinners** (e.g. aspirin, warfarin, Eliquis®, Lixiana®, Pradaxa®, Xarelto®) ◯ **Medications that affect the immune system** such as prednisone, other steroids, anticancer medications, transplant medications, medication used to treat inflammatory conditions (e.g. rheumatoid arthritis, Crohn's disease, psoriasis). If unsure, ask your pharmacist ◯ **Antiviral medications or antibiotics** (medications used to treat infection)	◯ Yes	◯ No
6. Are you **pregnant**, could you be pregnant or are you planning on becoming pregnant?	◯ Yes	◯ No
7. Are you **nursing/breastfeeding**?	◯ Yes	◯ No
8. Have you **received any vaccinations in the past 4 weeks** or have any **scheduled vaccines in the upcoming 4 weeks**?	◯ Yes	◯ No
Also answer Questions 9 & 10 if you will be receiving a COVID-19 vaccine		
9. Have you had a **previous COVID-19 infection**?	◯ Yes	◯ No
a. If yes to Q9, were you treated with **convalescent plasma** or **monoclonal antibodies**?	◯ Don't know ◯ Yes	◯ No
10. Are you **receiving a 3rd or 4th COVID-19 vaccine dose for travel purposes**? If yes, recipients need to sign this form.	◯ Yes	◯ No
Also answer Questions 11 to 13 if you will be receiving a live vaccine		
11. Do you **require a TB skin test** within the next 4 weeks or have you ever had a **positive TB skin test**?	◯ Yes	◯ No
12. Do you have **close contact** with anyone with a **weakened immune system**?	◯ Yes	◯ No
13. In the past year, have you received a **transfusion of blood/ blood products, or immune globulin (Ig)**?	◯ Yes	◯ No

Inactivated vaccines including Influenza Vaccine: Q1-8; COVID-19 vaccine: Q1 -10; Live vaccines: Q1-8 and 11-13

Vaccine Providers: see the accompanying guide for interpretation of responses

Last updated 24 Sep 2021

DECLARATION OF CONSENT:

- I have read or had explained to me the vaccine information sheet regarding the risks, benefits and potential side effects associated with the vaccine(s).
- I have had the opportunity to have my questions answered by the pharmacist and understand the information I have been given.
- I understand the need for observation by the vaccine provider for at least 15 minutes after my vaccination.
- I understand health information may be shared with another healthcare provider as necessary for care.
- I consent to the vaccine provider administering the vaccine for myself or my child /dependent.

Signature of: ◯ Vaccine Recipient ◯ Parent /Guardian ◯ Proxy

Name (if not signed by vaccine recipient)

Date

Assessing Pharmacist: _____

For Pharmacy Use Only

◯ Discussed publicly funded options (if applicable)

Vaccine: Name, Manufacturer, DIN*, LOT#, Expiry Date	Dosage	Site	Route	Dose #	Administered by (Name)	Date & Time of Injection
1.						
◯ Age appropriate ◯ Minimum interval met (if applicable)						
2.						
◯ Age appropriate ◯ Minimum interval met (if applicable)						
3.						
◯ Age appropriate ◯ Minimum interval met (if applicable)						
4.						
◯ Age appropriate ◯ Minimum interval met (if applicable)						

Adverse reaction: ◯ No ◯ Yes - Vaccine(s) implicated:
Describe reaction:

◯ Completed Adverse Event Following Immunization (AEFI) form

◯ Provided record of immunization

◯ Notified primary care practitioner (NOT for COVID-19 or Influenza) Name: Fax:

*Not required as per bylaws but good practice to record

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