botika LTC

# 2021/2022 Influenza Vaccine Consent Form

Touchscreen (iPad/Phone) recommended for ease of signature capture

**Name** *

First Name Last Name

**Medicare Number**

**Date of Birth** *

Month Day Year

**Facility Name** *

If individual, type in address & phone number

**Primary Care Provider** *

Prefix First Name Last Name

**Have you travelled to any countries outside Canada (including the United States) within the last 14 days?** *

- No
- Yes

**Are you experiencing cold, flu, or COVID-19-like symptoms, even mild ones? Symptoms include: fever, chills, cough, shortness of breath, sore throat/painful swallowing, stuffy/runny nose, loss of sense of smell, headache, muscle aches, fatigue, loss of appetite, conjunctivitis, dizziness, confusion, nausea, vomiting, abdominal pain, skin rashes, discolouration of fingers or toes -**

**or any other suspected COVID-19 symptoms?** *

- ○ No
- ○ Yes

**Within the last 14 days, did you provide care or had close contact with a person with confirmed COVID-19 or someone who is under investigation for COVID-19?** *

- ○ No
- ○ Yes

**Have you ever had a flu shot before?** *

- ○ Yes
- ○ No
- ○ I don't know

**Have you received any vaccinations in the last 6 weeks?** *

- ○ Yes
- ○ No
- ○ I don't know

**Have you ever fainted or had a serious reaction to any previous injection or vaccine(s) including Guillain- Barre Syndrome?** *

- ○ Yes
- ○ No

**Do you have an active neurological condition?** *

- ○ Yes
- ○ No

**Are you pregnant or breastfeeding?** *

Yes

No

**Have you received blood products (containing immunoglobulin) in the last 3 months? ***

Yes

No

**Do you have any allergies? Please list: (foods, medications, vaccine components) ***

Type No if no allergies

**Do you have any chronic health conditions or immunodeficiencies? Pleast list: ***

Type None if no health condition specified

**Are you currently on any medications or immunosuppressants? Please list: ***

Type None if not on any medication specified

- I have read or had explained to me and understand the benefits, side effects and risks of receiving and risks of not receiving the influenza vaccine.
- I have had the opportunity to ask questions and I have received satisfactory answers.
- I agree to be observed for at least 15 minutes after receiving the influenza vaccine or as directed, in the pharmacy or the clinic site by the pharmacists or staff.
- I authorize my pharmacist to notify my physician/nurse practitioner and/or public health of the vaccine received, any adverse events experienced and/or to contact me with any follow-up if needed.
- I consent to receive the influenza vaccine today OR I consent on behalf of the patient to receive the influenza vaccine today.

**Name of Signatory ***

Select Appropriate Title | First Name | Last Name

**Email**

A copy will be emailed to you.