

# 2021/2022 Influenza Vaccine Consent Form

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



#### **Medicare Number**

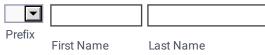
#### Date of Birth \*



# Facility Name \*

If individual, type in address & phone number

### Primary Care Provider \*



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



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? \*

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? \*

$\circ$	
No	
0	
<u> </u>	
Yes	

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

0	
Yes	
0	
No	
0	
I don't	know

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

0	
Yes	
0	
No	
0	
I don't	know

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

0
Yes
0

No

#### ....

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

0	
Yes	
0	
No	

# Are you pregnant or breastfeeding? \*

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

0
Yes
0
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 <u>I consent on behalf of the patient to receive the influenza vaccine today.</u>

#### Name of Signatory \*

	<u>,</u>	
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Select Appropriate Title	First Name	Last Name

#### Email

A copy will be emailed to you.

