

Section 1: Personal Information			
Patient First and Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No. (if applicable):	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Self-identify: _____ (This is collected for clinical assessment & reimbursement purposes)	Age:	Child's Weight: kg OR lb	Date of Birth (MM/DD/YYYY)
Name of Emergency Contact:		Contact's Daytime Phone Number:	
Emergency Contact's Relationship to Patient:		Contact's Evening/Other Phone Number:	

Section 2: Screening Questionnaire

The following questions will help us determine if there is any reason you or your child should not get the flu shot today. If you answer "yes" to any question, it does not necessarily mean the shot cannot be given, it simply means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

Please answer the following questions	Yes	No	Unsure	Action required
Have you been diagnosed with COVID-19 in the last 10 days or have been recommended to stay at home (self-isolate) based on the COVID-19 Self-Assessment tool?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> or <u>UNSURE</u> , speak to your pharmacist about whether you should get the flu shot today
Are you sick today ? (fever greater than 39.5°C, breathing problems, or active infection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do <u>NOT</u> get the shot today
Do you have any allergies that you are aware of?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , list what you are allergic to here:
Are you allergic to any of the following?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , your pharmacist can check whether the flu shot contains any of these potential allergens and possibly use one which does not. (If you have an allergy or reaction to egg/egg protein/chicken protein, speak to the pharmacist. You may be able to receive the flu shot but may <u>require a longer observation period post-administration.</u>)
Check all that apply:				
<input type="checkbox"/> Thimerosal				
<input type="checkbox"/> Egg/egg protein/chicken protein				
<input type="checkbox"/> Kanamycin				
<input type="checkbox"/> Neomycin				
<input type="checkbox"/> Polysorbate 80 or PEG				
Are you allergic to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> or <u>UNSURE</u> , do <u>NOT</u> get the shot and <u>SPEAK WITH YOUR PRIMARY CARE PROVIDER</u>
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> or <u>UNSURE</u> , you can receive the flu shot but non-latex materials are to be used
Do you have any serious allergy to latex or natural rubber?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do <u>NOT</u> get the flu shot and <u>SPEAK WITH YOUR PRIMARY CARE PROVIDER</u>
Have you had Guillain-Barré Syndrome within 6 weeks of getting a flu shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do <u>NOT</u> get the flu shot and <u>SPEAK WITH YOUR PRIMARY CARE PROVIDER</u>
Do you have a new or changing neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , do <u>NOT</u> get the flu shot and <u>SPEAK WITH YOUR PRIMARY CARE PROVIDER</u>
Do you have bleeding problems or use blood thinners ? (e.g., warfarin, low dose or regular strength aspirin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If <u>YES</u> , you can get the flu shot but apply gentle pressure afterwards

* Note to Pharmacy Professionals: Only some of the most common allergens are included here but any component in a vaccine could be a potential allergen.

Section 3: Consent Given By Patient/Agent

I, the client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the [Flu Shot Fact Sheet](#). I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the flu shot. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu shot.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called “anaphylaxis” can be life-threatening and are deemed medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 911 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include but is not limited to hives, difficulty breathing, and/or swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

I confirm that I want to receive, or want my child 2 years of age or older to receive, the seasonal influenza vaccine

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date Signed (MM/DD/YYYY)
PHARMACY PROFESSIONAL DECLARATION: I confirm the above named patient/agent is capable of providing consent, and if written/electronic consent cannot be obtained, the patient/agent has provided verbal consent for the administration of the seasonal influenza vaccine to the patient. Based on my professional judgement, seasonal influenza vaccine should be administered to the patient.		
Pharmacy Professional Signature	OCP License #	Date Signed (MM/DD/YYYY)

Section 4: Administration Information (Pharmacy Use Only)

INFLUENZA VACCINE		EPINEPHRINE EMERGENCY TREATMENT		
Patient Name:		Patient Name:		
<input type="checkbox"/> FLULAVAL TETRA – DIN 02420783 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial (age 2 or older)	<input type="checkbox"/> EpiPen® 0.3 mg/0.3 mL – DIN 00509558 Use PIN 09857423 for claims for adverse events within the UIIP			
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02432730 – QIV 15 mcg/0.5 mL – 5 mL (multi-dose) vial (age 2 or older)	<input type="checkbox"/> EpiPen Junior® 0.15 mg/0.3 mL – DIN 00578657 Use PIN 09857424 for claims for adverse events within the UIIP			
<input type="checkbox"/> FLUZONE® QUADRIVALENT – DIN 02420643 – QIV 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe (age 2 or older)	<input type="checkbox"/> Allerject® 0.3 mg/0.3 mL – DIN 02382067 Use PIN 09857440 for claims for adverse events within the UIIP			
<input type="checkbox"/> FLUZONE® HIGH-DOSE QUADRIVALENT – DIN 02500523 – QIV-HD 60 mcg/0.7 mL – 0.7 mL (single-dose) syringe (age 65 or older)	<input type="checkbox"/> Allerject® 0.15 mg/0.15 mL – DIN 02382059 Use PIN 09857439 for claims for adverse events within the UIIP			
<input type="checkbox"/> FLUAD® – DIN 02362384 – TIV-adj 15 mcg/0.5 mL – 0.5 mL (single-dose) syringe (age 65 or older)	<input type="checkbox"/> Emerade™ 0.5 mg/0.5 mL – DIN 02458454 Use PIN 09858130 for claims for adverse events within the UIIP			
	<input type="checkbox"/> Emerade™ 0.3 mg/0.3 mL – DIN 02458446 Use PIN 09858129 for claims for adverse events within the UIIP			
Vaccine Lot #:	Expiry (MM/YYYY):	Number of Doses Administered:		
Date and Time of Immunization:	Location of Immunization: <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other:	Date and Location of Administration:	Time(s) of Administration: 1. 2. (if applicable) 3. (if applicable)	
Dose: mL	Route: IM	Site of administration: <input type="checkbox"/> Left: <input type="checkbox"/> Right:	Administering Pharmacy Professional Name and OCP #:	Administering Pharmacy Professional Signature:
Administering Pharmacy Professional Name and OCP #:		Additional Notes (including other emergency measures taken or treatments administered):		
Administering Pharmacy Professional Signature:		Date and Time of Follow-up with Patient/Agent:		

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