Universal Influenza Immunization Program (UIIP) 2024/25

Screening Questionnaire and Consent Form

ONTARIO PHARMACISTS ASSOCIATION
Advocating Excellence

Section 1: Personal Information

Patient First and Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No. (if applicable):	
☐ Male ☐ Female ☐ 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" or "unsure" 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?	☐	☐	☐	If YES or UNSURE, speak to your pharmacist about whether you should get the flu shot today
Are you **sick today**? (fever, breathing problems, or active infection)	☐	☐	☐	If YES or UNSURE, speak to your pharmacist about whether you should get the flu shot today
Do you have any **allergies** that you are aware of?	☐	☐	☐	If YES, list what you are allergic to here:
Are you **allergic** to any of the following?* **Check all that apply:** ☐ Thimerosal ☐ Egg/egg protein/chicken protein ☐ Kanamycin ☐ Neomycin ☐ Polysorbate 80 or PEG	☐	☐	☐	If YES, 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 require a longer observation period post-administration.)
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?	☐	☐	☐	If YES or UNSURE, do NOT get the flu shot and SPEAK WITH YOUR PRIMARY CARE PROVIDER
Have you had **wheezing, chest tightness or difficulty breathing** within 24 hours of getting a flu shot?	☐	☐	☐	
Do you have any **serious allergy** to latex or natural rubber?	☐	☐	☐	If YES or UNSURE, you can receive the flu shot but non-latex materials are to be used
Have you had **Guillain-Barré Syndrome** within 6 weeks of getting a flu shot?	☐	☐	☐	If YES, do NOT get the flu shot and SPEAK WITH YOUR PRIMARY CARE PROVIDER
Do you have a **new or changing** neurological disorder?	☐	☐	☐	If YES, do NOT get the flu shot and SPEAK WITH YOUR PRIMARY CARE PROVIDER
Do you have **bleeding problems or use blood thinners**? (e.g., warfarin, low dose or regular strength aspirin)	☐	☐	☐	If YES, 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 in 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 were 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

Patient Name:

☐ FLULAVAL® TETRA – DIN 02420783 – QIV
15 mcg/0.5 mL – 5 mL (multi-dose) vial **(age 2 or older)**

☐ FLUZONE® QUADRIVALENT – DIN 02432730 – QIV
15 mcg/0.5 mL – 5 mL (multi-dose) vial **(age 2 or older)**

☐ FLUZONE® QUADRIVALENT – DIN 02420643 – QIV
15 mcg/0.5 mL – 0.5 mL (single-dose) syringe **(age 2 or older)**

☐ FLUCELVAX® QUAD – DIN 02494248 – QIV
15 mcg/0.5 mL – 0.5 mL (single-dose) syringe **(age 2 or older)**

☐ FLUZONE® HIGH-DOSE QUADRIVALENT – DIN 02500523 – QIV-HD
60 mcg/0.7 mL – 0.7 mL (single-dose) syringe **(age 65 or older)**

☐ FLUAD® – DIN 02362384 – TIV-adj
15 mcg/0.5 mL – 0.5 mL (single-dose) syringe **(age 65 or older)**

Vaccine Lot #:

Expiry (MM/YYYY):

Date and Time of Immunization:

Location of Immunization:
☐ Pharmacy
☐ Other:

Dose: mL

Route: **IM**

Site of administration:
☐ Left:
☐ Right:

Administering Pharmacy Professional Name and OCP #:

Administering Pharmacy Professional Signature:

EPINEPHRINE EMERGENCY TREATMENT

Patient Name:

☐ EpiPen® 0.3 mg/0.3 mL – DIN 00509558
Use *PIN 09857423* for claims for adverse events within the UIIP

☐ EpiPen Junior® 0.15 mg/0.3 mL – DIN 00578657
Use *PIN 09857424* for claims for adverse events within the UIIP

☐ Allerject® 0.3 mg/0.3 mL – DIN 02382067
Use *PIN 09857440* for claims for adverse events within the UIIP

☐ Allerject® 0.15 mg/0.15 mL – DIN 02382059
Use *PIN 09857439* for claims for adverse events within the UIIP

Number of Doses Administered:

Date and Location of Administration:

Time(s) of Administration:
1.
2. *(if applicable)*
3. *(if applicable)*

Administering Pharmacy Professional Name and OCP #:

Administering Pharmacy Professional Signature:

Additional Notes (including other emergency measures taken or treatments administered):

Date and Time of Follow-up with Patient/Agent: