WEREZAK'S PHARMACY
PharmaChoice

CONSENT FOR INFLUENZA VACCINE ADMINISTRATION

Patient Name: _____ **Gender:** _____

Valid Sask Health# (PHN): _____ **Date of Birth:** _____

Phone#: _____ **Address:** _____

Screening **The following questions will help determine if a vaccine is right for you today. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist should be aware of it and may have some additional questions for you. Do you (or your child / dependent):**	**YES**	**NO**
1. Do you feel sick today?		
2. Have allergies to medications, food, a vaccine component, or latex?		
3. Have a history of serious reaction after receiving a vaccination?		
4. Have any of the following medical conditions (check all that apply ☐ bleeding problems ☐ brain or nervous system disorders (e.g. seizures) ☐ asthma ☐ caner, HIV/AIDS or other immune system disorders		
5. Take any of the following medications (check al that apply): ☐ blood thinners (e.g. aspirin, warfarin) ☐ drugs used to treat immune system disorders such as prednisone, other steroids, or anticancer drugs ☐ drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis ☐ antiviral drug		

Informed Consent

- I agree to remain at the location for 15 minutes or for the duration specified/directed by the Pharmacist.
- I understand that there are possible adverse effects associated with administration of the below mentioned vaccine.
- I understand that I may, at any time before, during or after the injection, ask the pharmacist further questions.
- In the event of an emergency, I authorize the Pharmacist to administer epinephrine and/or perform any necessary lifesaving procedures until medical support arrives. In the case of an emergency, please contact:

Emergency Contact: _____ **Phone#:** _____

- I understand that I may experience symptoms following influenza immunization *(i.e. Cough, Fever, etc)* that are similar to symptoms that present with COVID-19 infection and am aware to contact my public health line if symptoms occur.
- I understand that the Pharmacist will comply with all professional standards for administering injections. I acknowledge that the Pharmacist has discussed the risks and benefits of receiving this injection with me and has answered my questions.

Patient Signature (Guardian): _____ **Date:** _____

FOR PHARMACIST USE ONLY

VACCINE INFORMATION:			**PHARMACY INFORMATION:**	
Vaccine Name:			**Pharmacist Signature:**	
Dose (ml):			**License#:**	
Lot#:			**Date of Administration:**	
Expiry Date:			**Time of Administration:**	
Vaccination Site:	☐ **Left Arm**	☐ **Right Arm**	**Route:**	☐ **Intramuscular**
Adverse Reaction:	☐ **No**	☐ **Yes**	**Describe Reaction:**	