VACCINATION CONSENT FORM

Patient Name First _____ Last _____
Address _____
Date of Birth (dd/mm/yyyy) _____ Phone Number _____
Emergency Contact _____ Phone Number _____
Health Care Number _____

Please Answer the Following Questions:

As of Today:	**Yes**	**No**
Is this the first time you are receiving this vaccine?		
Have you ever fainted or had a serious reaction to any previous vaccine(s)?		
Have you received any vaccinations in the last 6 weeks?		
Do you have a fever, an active infection, or feel unwell?		
Are you allergic to: ☐Eggs ☐ Egg Products ☐Thimerosal (a preservative) ☐Latex ☐Medications If yes, please describe the reaction: _____ _____		
Do you have any chronic health conditions or immune-deficiencies? (e.g. asthma, diabetes, HIV, cancer) If yes, please list: _____		
Are you currently on any medications or immune-suppressants? If yes, please list: _____ _____		
Do you have an active neurological condition (seizure disorder)?		
Do you have any bleeding disorders or are you taking any blood-thinners?		
If female, are you pregnant, planning to become pregnant in the next month, or breast feeding?		
Have you received blood products (containing immune-globulin) in the last 3 months?		
If you are older than 50 years of age, have you had the shingles vaccine?		
Have you had or do you have Gullain-Barre Syndrome?		
Are you a smoker?		

Side effects from vaccination typically resolve within 2 to 3 days and in most cases, an analgesic such as acetaminophen or ibuprofen may be taken to reduce fever and/or discomfort.
Common side effects: soreness, tenderness, redness, and/or swelling in the area of the injection site.
Less frequent side effects: mild fever, headache, and/or muscle aches.
Due to a very rare possibility of an allergic or other reaction (about 1 for every one million vaccinations), please remain in the pharmacy for at least 20 minutes after your vaccination. If you develop a high fever or unexpected or prolonged side effects (lasting more than 2 days after vaccination), contact your doctor promptly.

PATIENT CONSENT

- I have read and understood the information provided to me regarding the benefits, side effects, and risks associated with the following injections (*as indicated on the back of this form*) administered today.
- I have had the opportunity to have my questions answered.
- I/my dependent, agree to remain at the pharmacy for at least 20 minutes following immunization.
- I authorize my pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction.
- I authorize my pharmacist to contact me about a follow-up dose if required.

I hereby give my consent to receive the injections (*indicated on Page 2*) today, and release Pharmasave #_____ and the vaccinating pharmacist/healthcare professional _____ from any and all liability.
Print Name: _____ Signature: _____

VACCINATION CONSENT FORM

Date (dd/mm/yyyy): _____

RECORD OF ADMINISTRATION TO BE COMPLETED BY THE INJECTION PHARMACIST

Date (dd/mm/yyyy): _____ Time: _____ (am/pm)

Injection Site: _____ Left Side ☐ Right Side ☐

Vaccination Name: _____Afluria DIN: 02473283

Dose: 0.5 ML Expiration Date (dd/mm/yyyy): 20/06/2020

Lot Number: P100236356

Comments: _____

Name of Injection Pharmacist (please print): Yakoot Elhawwash #11408

Signature of Injection Pharmacist: _____