Inactivated Vaccine Consent Form

Section 1: Patient Information

Date (MM/DD/YYYY):				
Last Name:	First Name:	Prov. Health Number:	Gender:	Age:
Main Phone Number:	Alternate Phone Number:	Date of Birth (MM/DD/YYYY):	Child's weight: (kg / lb)	
Address: City: Province:		Postal Code:	Alberta residents: Are you a healthcare worker? ☐ Yes ☐ No	
Emergency Contact's Last Name:	Emergency Contact's First Name:	Relationship:	Contact's Main Phone Number:	Contact's Alternate Phone Number:

Section 2: Screening Questionnaire

	Yes	No	Unsure
Are you/your child currently sick today or have been **sick in the past 3 days**? (fever > 39.5°C, difficulty or change in breathing, active infection)			
Have you had difficulty breathing, wheezing or chest tightness within 24 hours of getting a vaccine?			
Do you/your child have any **allergies** to medications, food, a vaccine component or latex?			
Have you/your child ever had a reaction to egg or egg products but can still eat small amounts of egg? (e.g. stomach ache, skin reaction)			
Do you/your child have any immediate or upcoming surgeries?			
Do you/your child have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?			
Do you/your child have bleeding problems or take blood thinners? (e.g. warfarin)			
Have you/your child ever had a seizure or a brain/nervous system problem?			
In the past 3 months, have you/your child taken any medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
Are you/your child currently pregnant, breastfeeding or plan to be pregnant?			
Have you/your child ever had Guillain-Barré Syndrome within 6 weeks of getting a vaccine?			
Have you/ child ever had Oculo-Respiratory Syndrome after getting the flu vaccine?			
Have you received your pneumonia vaccines? If yes, which vaccine_____ and when: _____			
Have you received your meningococcal vaccines? If yes, which vaccine_____ and when: _____			

Section 3: Consent Given By Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the vaccine. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the vaccine. I agree to wait in the clinic/pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the vaccine.

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 medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try and treat this reaction and that 9-1-1 will be called to provide additional assistance. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, 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 consent that information collected on this form may be shared with my Primary Care Provider and provincial public health unit.

I confirm that I/my child want to receive ☐ **the seasonal influenza vaccine** ☐ the pneumonia vaccine ☐ the meningococcal vaccine ☐ the shingles vaccine

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date Signed (MM/DD/YYYY)

PHARMACY USE ONLY – Section 4: Prescription Templates – Vaccine Used

HEALTH CARE PROVIDER'S DECLARATION:

☐ I confirm the above named patient is capable of providing consent for the vaccine and that the vaccine should be given to the patient. I am administering the vaccine no more than 21 days after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient.

Trivalent Influenza Vaccine:	☐ **AGRIFLU®** 0.5 mL IM DIN 02346850	☐ **FLUAD®** 0.5 mL IM DIN 02362384	☐ **FLUAD Pediatric®** 0.25 mL IM DIN 02434881	☐ **FLUVIRAL®** 0.5 mL IM DIN 02420686	☐ **FLUZONE High-Dose®** 0.5 mL IM DIN 02445646	☐ **INFLUVAC®** 0.5 mL IM DIN 02269562	☐ **VAXIGRIP®** 0.5 mL IM DIN 02367718

Quadrivalent Influenza Vaccine:	☐ **FLULAVAL® TETRA** 0.5mL single-dose vial DIN 02420783	☐ **FLUZONE® QUADRIVALENT** 0.5mL single-dose vial DIN 02420643 / 5mL multi-dose vial DIN 02432730	☐ **AFLURIA® TETRA** 0.5ml pre-filled syringe DIN 02473283 / 5ml multi-dose vial DIN 02473313

Other Vaccine:	☐ **Prevnar®** 0.5 mL IM DIN 02335204	☐ **Trumenba®** 0.5 mL IM DIN 2468751	☐ **Nimenrix®** 0.5 mL IM DIN 2402904	☐ **Shingrix®** 0.5 mL IM DIN 2468425	Arm Administration Site: ☐ Left ☐ Right	Vaccine Lot #:	Vaccine Expiry (MM/YYYY):

Date of Immunization (MM/DD/YYYY):	Time of Immunization:	Vaccine Lot #:	Vaccine Expiry (MM/YYYY):	Health Care Provider's Name & License #:	Signature:

Influenza Vaccine Arm Administration Site: ☐ Left ☐ Right	Contacted Primary Prescriber: ☐ Yes ☐ No	Emergency Treatment: ☐ Yes ☐ No

Take control of your health now – get vaccinated at the convenience of your own local pharmacy.

Pneumococcal Disease

Pneumococcal disease is a concern all year long but is more common during the winter and spring months here in Canada. Pneumonia can be fatal and may target those diagnosed with diabetes.

Here are some key facts:

- You are at risk if:
  - you are > 50 years of age
  - you have asthma, COPD, chronic heart disease, liver disease, diabetes or cancer
- Up to 43% of people diagnosed with pneumonia in the emergency department end up admitted to a hospital
- Influenza and pneumonia are #6 on the list for "Top 10 Causes of Death in Canada"

Ask your healthcare provider about the **pneumococcal pneumonia vaccine** to decrease your risk of pneumonia. You may also ask your healthcare provider about the shingles vaccine.

Invasive Meningococcal Disease

Invasive Meningococcal Disease (IMD) is a serious bacterial infection which can lead to dangerous and sometimes fatal diseases such as meningitis (inflammation of the lining of the brain and spinal cord) and blood poisoning (sepsis).

Here are some key facts:

- IMD can be fatal within 24 hours of first symptoms. Even when the disease is treated early, 5-10% of patients die, typically within 24-48 hours after symptoms start
- Adolescents and young adults **15-24 years** have a high rate of IMD
- IMD has historically occurred in schools, colleges, camps and other places where there are large numbers of adolescents and young adults. It can be spread through direct contact, kissing, sharing cups, drinks and utensils and living in close quarters

If a prescription is required, we can contact your prescriber! Talk to your pharmacist to see what they can do for you and your vaccination health today.