



Injectable Vaccine Screening Tool and Consent Form

Patient information				
Name: (Last, First)	Date of birth (YYYY-M	M-DD)		
Address:				
Health Services Number:	Gender: M / F	Weight:		
Daytime Phone Number:	Alternate Phone Num	nber:		-
Emergency Contact Information Name:	Phone Number:			
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): 1. Feel sick today?			□Yes	□ No
2. Have allergies to medications, food, a vaccine component, o	r latex?		□Yes	□No
3. Have a history of serious reaction after receiving a vaccin	nation?		☐ Yes	□ No
4. Have any of the following medical conditions: ☐ bleeding problems ☐ asthma ☐ cancer, HIV/AIDS or other immune system disorders				
5. Take any of the following medications (currently, recently): □ blood thinners (aspirin, warfarin) □ drugs used to treat immune system disorders such as predr □ drugs for the treatment of rheumatoid arthritis, Crohn's dise □ antiviral drugs		or anticancer drugs		
6. Require a TB skin test within next 4 weeks? Have a history of a	a positive TB skin test	?	□Yes	□No
7. Have close contact with anyone with a severely weakened in			□ Yes	□ No
8. For women: Are you pregnant or is there a chance you could b9. Have a history of any vaccinations in the past 4 weeks?	ecome pregnant durin	ig the next month?	☐ Yes	□ No
10. During the past year, have a history of receiving a transfusion (gamma) globulin?	of blood or blood prod	ducts, or immune	□ Yes	□ No
Q1-5 Injectable inactivated influenza vaccine Q1-8 Live attenuated influenza vaccine Q1-10 Other vaccines				
Declaration of Consent:				• •
I confirm that I have read or had explained to me the attached vaccine information sheet regarding the risks, benefits and potential side effects associated with the vaccine. I have had the opportunity to have my questions answered by the pharmacist and am satisfied with and understand the information I have been given. I consent to receiving or my child /dependent receiving this vaccine.				
Signature of: ☐ Vaccine recipient ☐ Parent /guardian	□ Proxy	Date		
For Pharmacist Use Only				
		acist Signature Date	&Time of Ir	njection
	M SC N			
Adverse reaction: ☐ No ☐ Yes – describe reaction:		Cost:		
□ Notified primary care practitioner (if applicable): Name □ Reported immunization to electronic provincial registry (if appli		Fax #:		
☐ If first influenza vaccination, age 5 to less than 9 years, appointment date for 2 nd injection:				