Screening Questionnaire For Inactivated Injectable Influenza Vaccine

Section 1: Personal Information

Patient First & Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No:	
☐ Male ☐ Female	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

For adult patients as well as parents of children (≥ 5years) to be vaccinated:

- Covid-19 Questionnaire:

Have you travelled outside of Canada in the past 14 days? ☐ *Yes* ☐ *No*

Do you have any of the following Symptoms: Fever, Cough, Difficulty Breathing, Sore Throat, Runny Nose, Loss of Taste and Smell, Nausea, Vomiting or Diarrhea? ☐ *Yes* ☐ *No*

Have you been in close contact with someone who has confirmed COVID-19 in the past 14 days without wearing appropriate PPE? ☐ *Yes* ☐ *No*

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" 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
Are you **sick today**? (fever greater than 39.5°C, breathing problems, or active infection)	☐	☐	☐	If YES, do NOT get the shot today
Are you **allergic** to any medications including vaccines?	☐	☐	☐	If YES, list what you are allergic to here:
Are you **allergic** to any of the following? Check all that apply: ☐ Kanamycin ☐ Neomycin ☐ Gentamicin ☐ Thimerosal ☐ Chicken protein	☐	☐	☐	If YES, your pharmacist can check whether the flu shot contains any of these potential allergens and use one which does not.
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 shot & SPEAK WITH YOUR MD
Have you had **wheezing, chest tightness or difficulty breathing** within 24 hours of getting a flu shot?	☐	☐	☐	
Have you had a severe reaction to **eggs or egg products**? (e.g. wheezing, chest tightness, difficulty breathing, hives)	☐	☐	☐	
Have you had a reaction to **eggs or egg products** but can still eat small amounts of egg? (e.g. stomach ache)	☐	☐	☐	If YES or UNSURE, you can receive the flu shot but MUST BE OBSERVED FOR 30 MINUTES AFTERWARDS
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
Do you have a **new or changing** neurological disorder?	☐	☐	☐	If YES, do not get the flu shot & SEE YOUR MD
Do you have **bleeding problems or use blood thinners**? (e.g. warfarin, low dose or regular strength aspirin)	☐	☐	☐	If YES, shot can be given but apply gentle pressure afterwards

Consent Form & Rx Template 2021–22

Section 3: Consent Given By Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on 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 is a medical emergency. 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 9-1-1 will be called to provide additional assistance to the immunizer. 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 confirm that I want to receive the seasonal influenza vaccine**

OR

☐ **I confirm that I want my child to receive the seasonal influenza vaccine**

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

PHARMACIST DECLARATION: I confirm the above named patient is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient.

Pharmacist Signature	**OCP License #**	**Date Signed** (MM/DD/YYYY)
	612654	

Section 4: Prescription Templates – Pharmacy Use Only

INFLUENZA VACCINE

Patient Name:

☐ FLUVIRAL®– DIN 02420686 – TIV
15 mcg/0.5mL – 5 mL (multi-dose) vial

☐ Fluzone® – DIN 02420643 – QIV
15 mcg/0.5mL – 0.5 mL (single dose) syringe

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

☐ FLUCELVAX QUAD – DIN 02494248 – QIV
15 mcg/0.5mL – 0.5 mL (single-dose) syringe

☐ FLUZONE High Dose – DIN 02500523
0.7 mL (single-dose) syringe

Vaccine Lot:	Expiry (MM/YYYY):
Date of Immunization:	Time of Immunization:

Dose	Route	Site of administration
0.5 ml	**IM**	☐ Left: _____ ☐ Right: _____

Administering Pharmacist Name and OCP #:
Mark Ayoub 612654

Administering Pharmacist Signature:

EPINEPHRINE EMERGENCY TREATMENT

Patient Name:

☐ EpiPen®
DIN 00509558 – *PIN 09857423*

☐ EpiPen® Junior
DIN 00578657 – *PIN 09857424*

Number of Doses Administered:

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

Administering Pharmacist Name and OCP #:	Administering Pharmacist Signature:

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

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