Rexall®

Vaccination Consent Form

By provincial legislation, Pharmacists cannot administer certain vaccines to children under a certain age. Ask your pharmacist for age restrictions.

Name:		**Provincial Health Number:**
Date of Birth (MM/DD/YYYY):	Age:	Gender:
Address:		Patient Phone:
Emergency Contact Name:	Contact Phone:	Relationship to Patient:

Injection Screening Questionnaire

	✔Yes	✖No
1. Are you sick today? (fever greater than 39.5°C, breathing problems, or active infection)		
2. Have you had this vaccine or a similar vaccine before? If yes, please specify date of last shot:		
3. Is your immune system affected by a severe disease or medication? If yes, plese specify:		
4. Are you pregnant or breastfeeding/nursing?		
5. Do you have any allergies? Including: medications; vaccines; eggs or egg product; latex or natural rubber; and polyethylene glycol or polysorbate If yes, please specify:		
6. Have you ever had a severe reaction (e.g. Guillain-Barre Syndrome, allergic reaction) or have experienced fainting, wheezing, chest tightness, or difficulty breathing following a vaccine? If yes, please specify:		
7. Have you received any other vaccines in the last 4 weeks? If yes, please specify:		
8. Do you have a bleeding disorder or are taking blood thinners? If yes, please specify: (e.g. Warfarin, Apixaban, Rivaroxaban, Clopidogrel)		

Consent

I, the undersigned client, parent or guardian have read or had explained to me information about the vaccine and understand the benefits and possible reactions of the vaccine including the risk of not getting vaccinated. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine listed below unless the consent is cancelled. I agree to wait in the clinic or pharmacy for 15 minutes (or the time recommended by the pharmacist) after receiving the injection and will seek medical attention if needed. Furthermore I will report any adverse effects I experience to the immunizing pharmacist. I understand the information contained on this form, may be disclosed to public health authorities or your health care professionals and to other parties for the purpose of adverse event and drug safety reporting, as well as other purposes as authorized and required by law. I understand that the information will be used for outreach, including next dose reminders, as well as potential subsequent immunization campaigns.

Name: (Print) **Patient/Agent Signature:**

Date signed: (MM/DD/YYYY) ☐ Patient verbal consent provided.

FOR PHARMACIST USE ONLY

☐ Flu ☐ Flu-HD High Dose ☐ COVID-19 ☐ RSV ☐ Zoster Vaccine (Shingles) ☐ Pneumonia Vaccine ☐ Other: (Specify)

Vaccine #1: (Print Vaccine Name)

DIN: _____ Lot #: _____ Expiry Date: _____

Dose: _____mL ☐ Left Arm ☐ Right Arm ☐ Other _____

Route: Intramuscular ☐ Subcutaneous ☐ Intradermal ☐ Intranasal ☐

Diluent: _____ DIN: _____

Qty: _____mL Lot: _____ Expiry: _____

Vaccine #2: (Print Vaccine Name)

DIN: _____ Lot #: _____ Expiry Date: _____

Dose: _____mL ☐ Left Arm ☐ Right Arm ☐ Other _____

Route: Intramuscular ☐ Subcutaneous ☐ Intradermal ☐ Intranasal ☐

Diluent: _____ DIN: _____

Qty: _____mL Lot: _____ Expiry: _____

Pharmacy Information

Pharmacist signature: License number:

Date of administration (YYYY/MM/DD): Time of administration:

Additional Eligibility Criteria

☐ Chronic/High Risk: (Specify)

☐ Healthcare Provider ☐ Other congregate living

☐ Household High Risk ☐ High Risk Community

Patient Response

Notes:

Faxed to Public Health Unit: ☐ Yes ☐ No

Name of Public Health Unit & Fax #: _____

Faxed to Physician: ☐ Yes ☐ No

Name of Physician & Fax #: _____