Triumf - FLU clinic 2021/22 NOV 4th 2021

Pharmacy Use Only
COVID-19 screening has been conducted and the Patient does not present symptoms of COVID-19 or present with risk of exposure to COVID-19. ❑ *Yes* ❑ No

SEASONAL INFLUENZA VACCINATION SCREENING AND CONSENT FORM

Please complete this form and read the document entitled "Preparing for Your Influenza Vaccine" before receiving the seasonal influenza vaccine. Your answers to these questions will help the Pharmacist determine if there is any reason why you should not receive this vaccine. If you are a parent or guardian providing consent for a child or other person, please complete this form for the person being vaccinated.

PATIENT INFORMATION

Legal First and Last Name:		
Age:	Date of Birth: _____ / _____ / _____ (yyyy / mm / dd)	*(collected for clinical assessment & reimbursement)* Sex: ❑ Male ❑ Female ❑ _____ (self-identify)
Address: Street Apartment City Province Postal Code		
Health Card #: (Personal Health Identification Number)	Telephone:	
Emergency Contact Name and Phone Number:		

If you have questions and/or concerns about this form or the vaccine, please speak with the Pharmacist at:

Shoppers Drug Mart 2273
Address:5940 University Blvd, Dentistry Bldg
Vancouver, British Columbia V6T 1Z3
Phone: 604-228-1533
Fax: 604-228-1532
Email: asdm2273@shoppersdrugmart.ca
INSURANCE Information:
Group ID: _____
Member ID: _____
Carrier ID: _____
Relationship code: _____

Store Stamp

Screening Questionnaire for Person to be Vaccinated	Yes	No
Are you sick today (i.e. fever greater than 39.5℃, nasal congestion, breathing problems, active infection)?		
Have you ever had a serious reaction after receiving a vaccination in the past?		
Do you have an allergy to any of the components of the influenza vaccine? *(e.g. gentamicin, kanamycin, neomycin, thimerosal, formaldehyde)*		
Do you have any allergies? (including: medications, food, or latex)?		
Do you take blood thinner (aspirin, warfarin, dabigatran, rivaroxaban, apixaban, edoxaban, etc) or have bleeding problems?		
Have you developed Guillain-Barré syndrome within 6 weeks of previous influenza vaccination?		
If the Patient is less than 9 years old, are they receiving the influenza vaccine for the first time?		
Optional Screening Questions: Your answers to these questions help the Pharmacist determine your current immunization status and assist in providing adult vaccine recommendations. This information is NOT required to administer an influenza vaccine.	Yes	No
If you are 50 years or older, have you received a Shingles vaccine in the past?		
If you are 50 years or older, have you received a Pneumococcal vaccine in the past?		
Have you received all recommended doses of a complete COVID-19 vaccine series?		

Seasonal Influenza Vaccination Patient/Agent Consent

I consent to having the Health Care Professional (HCP) administer the seasonal influenza vaccine. I have reviewed the document entitled "Preparing for Your Influenza Vaccine" and the pharmacist has answered my questions. I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the Pharmacy at minimum 15 minutes after receiving the vaccination. I agree to see a doctor if I develop any side effects or health problems after receiving the vaccine. I agree that the Pharmacy may share my personal health information regarding this vaccination as required with public health officials and other healthcare providers.

SCAN ME

Preparing for Your Influenza Vaccine:

Scan the QR code with your smart phone camera to review information about the influenza vaccine, or ask the Pharmacy Team for a printed copy.

If providing consent for Patient identified above, complete below:

Contact information of Patient's agent (name and telephone): _____

Relationship to person receiving the seasonal influenza vaccination:

❑ *Parent* ❑ *Guardian* ❑ *Other, please specify* _____

❑ I am providing consent for myself ❑ I am providing consent for the Patient identified above.

Name of person providing consent: * _____

Signature of person providing consent:

*

Date: 2021 / 11 / 04 (yyyy / mm / dd)

SHOPPERS DRUG MART

Additional Screening Questions for Live Vaccines: (Flu Mist)	Yes	No
Do you have any of the following medical conditions? (severe asthma, cancer, HIV/AIDS or other immune system disorders)		
Do you take any of the following medications (currently, recently)? • drugs used to treat immune system disorders such as prednisone, other steroids, anti-cancer drugs; or • drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, other immune system conditions; or • antiviral drugs		
Do you have close contact with anyone with a severely weakened immune system?		
Are you pregnant? Or is there a chance of pregnancy during the next month?		
Have you received any vaccines in the past 4 weeks?		
Are you under 18 years of age and taking medication containing ASA?		

Pharmacy Use Only – Pharmacist Documentation

Standard QIV (IIV4-SD)	Standard QIV (IIV-cc)	Adjuvanted (IIV-Adj)	High-Dose (IIV-HD)	Live Attenuated (LAIV)
❑ Afluria Tetra (Pre-Filled Syringe) (DIN 02473283)	❑ Flucelvax Quad (DIN 02494248)	❑ Fluad (DIN 02362384)	❑ Fluzone High-Dose Quadrivalent (DIN 02445646)	❑ FluMist Quadrivalent (DIN 02426544)
❑ Afluria Tetra (MultiDose Vial) (DIN 02473313)		❑ Fluad Pediatric (DIN 02434881)		
❑ Flulaval Tetra (DIN 02420783)			Other: _____	
❑ **Fluzone Quadrivalent** (DIN 02432730) LOT:UJ707AC EXP:30June22	☐ **Fluzone Quadrivalent** (DIN 02420643) LOT: UJ688AA EXP:30June22		DIN: _____	
☑ Influvac Tetra (DIN 02484854) LOT: Z21EXP:30June22				

Dose: ☑ 0.5 mL ❑ _____ | Route of administration: ☑ IM ❑ Intranasal | Lot number: | Expiry:

Site: Deltoid ❑ Left ❑ Right | Date of administration: 2021 (yyyy) / 11 (mm) / 04 (dd) | Time of administration: _____ AM / PM

Rationale for vaccination	❑ Prevention of influenza; no contraindications Other comments:
Patient counseling	❑ Potential adverse reactions and their management ❑ Other:
Patient response	Before vaccination administration/vaccination: ☐ No Side effects ☐ Other: _____ During administration: ☐ No Side effects ☐ Other: _____ After waiting period: ☐ No Side effects ☐ Other: _____
Adverse reactions	Did the Patient have an adverse reaction? ❑ Yes ❑ No (*If yes, describe nature of the reaction and action(s) taken)* _____
Follow-up	❑ Yes ❑ No *(If yes, describe the reason for follow-up and timing)* _____
Communication	❑ Public Health ❑ Healthcare provider Name: _____ Method of notification: ❑ Fax ❑ Phone ❑ Other: _____ Date notified: _____

I confirm that the Patient named in this document is capable of, and has provided consent for, the seasonal influenza vaccination, or that a parent/guardian or other agent has provided consent on behalf of the Patient. I confirm that the seasonal influenza vaccine should be given to the Patient based on my assessment. I confirm that the Patient has provided verbal consent.

Name and Desgination of Health Care Professional (HCP) administering vaccine: ✓ ☐ Benny Sio (15626) ☐ Ryan Kullar (09887)

HCP License Number: See above HCP Signature: _____

Updated: June 2021