SEASONAL INACTIVATED INFLUENZA VACCINATION SCREENING AND CONSENT FORM

Please complete this form to consent to receiving your influenza vaccine. Must be printed and completed for each patient.
Your answer to these questions will help the provider determine if there is any reason why you should not receive this vaccine.

PATIENT INFORMATION

Last Name:	First Name:
Date of Birth: / / yyyy mm dd	Telephone:
Health Card #:	

Screening Questionnaire for Person to be Vaccinated	Yes	No
Are you sick today (i.e., fever greater than 38.0˚C, breathing problems, active infection)?		
Is this the first time you are receiving an influenza vaccine?		
Have you had a serious reaction to the influenza vaccine before or any components of the vaccine? *(e.g., gentamicin, neomycin, kanamycin, thimerosal, formaldehyde)*		
Do you have a history of Oculo-Respiratory Syndrome (ORS) or developed Guillain-Barre Syndrome (GBS) within 8 weeks of getting the influenza vaccine?		

COVID-19 Screening

I confirm that I:

☐ Am not experiencing any symptoms of COVID-19 detailed in the list presented to me.

☐ Have not travelled outside of Canada in the past 14 days.

☐ Have not been in contact with someone known to have COVID-19.

Seasonal Inactivated Influenza Vaccination Patient/Agent Consent

I verbally consent to having the Provider administer the seasonal inactivate influenza vaccine. I understand the risks, benefits, expected outcomes, and possible effects of this vaccine. I agree to go see a doctor if I develop any side effects or health problems after receiving the vaccine. I agree that the organization may share personal health information regarding this vaccination as required by public health officials or other healthcare providers. I consent to be contacted by telephone by the organization regarding this vaccination.

Signature: _____ _____

Date: / / yyyy mm dd

Relationship to minor if signing on their behalf.

Office Use Only - Documentation

Lot Number:	☐ Flulaval Tetra ☐ Agriflu ☐ Fluad
Site: Deltoid ☐ Left ☐ Right	Date of Administration: **2020** / **11** / yyyy mm dd
Name and Title of Provider Administering Vaccine:	
Provider Licence Number:	