Immunization Record

Prince Edward Pharmacy Ltd., 324 Prince Edward Drive South, Toronto ON M8Y 3Z5

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PATIENT INFORMATION **TRACKING #: ___**

First Name	*Last Name*	*Gender*	*DOB*	*Weight*
Address			*Health Card #*	*Phone #*
Emergency Contact		*Relationship to Patient*	*Contact's Phone Number*	*Contact's Other Phone #*

SCREENING QUESTIONNAIRE

The following questions will help us determine if there is any reason you or your child should not get vaccine today.
If your answer is "Yes" to any question, it does not necessarily mean that shot cannot be given.
It simple means additional questions must be asked.

If question is not clear please ask your pharmacist to explain it.

Are you sick today? (i.e. fever greater than 39.5 ^{o}C, breading problems or active infection)		Yes	No	Unsure
Do you have new or changing neurological disorder?		Yes	No	Unsure
Have you had a serious reaction to influenza vaccine in the past?		Yes	No	Unsure
Have you ever had Guillain-Barré syndrome within 6 weeks after receiving the flu vaccine?		Yes	No	Unsure
Have you ever experienced difficulty breading within 24 hours of getting the flu shot?		Yes	No	Unsure
Do you have an allergy to eggs or egg products?		Yes	No	Unsure
Do you have an allergy to kanamycin, neomycin, gentamicin, thimerosal, chicken protein, polymixin or gelatin		Yes	No	Unsure
Are you allergic to latex gloves?		Yes	No	Unsure
Are you currently taking any medication?		Yes	No	Unsure
Do you have history of chronic illness?		Yes	No	Unsure
Do you take blood thinner or have a bleeding disorder?		Yes	No	Unsure
Are you or do you think you might be pregnant?	N/A	Yes	No	Unsure

CONSENT GIVEN BY PATIENT / AGENT

I, the undersigned client, patient or guardian have read or had explained to me information about the flu shot as outlined on the Fact Sheet. I have had a 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 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 breading, swelling of the tongue, throat and / or lips.

In the event of anaphylaxis, I will receive 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

If you child is less than 9 years of age, and getting influenza vaccine for the first time, your child will need 2 doses of the vaccine this season. They are given at least 4 weeks apart.

Patient / Agent Name(& Relationship)	*Patient Agent Signature*	*Date Signed*
PHARMACIST DECLARATION I confirm that above named patient is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to patient.		
Pharmacist	*Pharmacist Signature*	*Date Signed*