

Influenza Screening Questions & Consent Form
You must remain in the clinic area 15 minutes after the vaccination is given.

Last name: _____	First name: _____
Date of birth: _____ yyyy / mm / dd	Age: _____
Complete address: number _____ street _____ city _____ province _____ postal code _____	
Telephone number: (_____) _____	

Answer the questions about your medical history. If you answer “yes”, briefly describe.

1. Are you feeling sick? Any fever?	☐ No ☐ Yes: _____
2. Have you ever had the influenza vaccine before?	☐ No ☐ Yes
3. Have you ever had a reaction to a vaccine before?	☐ No ☐ Yes: _____
4. Do you have any allergies to foods or medications?	☐ No ☐ Yes: _____
5. Do you have an allergy to a component of the influenza vaccine being administered? (e.g. thimerosal, formaldehyde, polysorbate 80, Polyethylene Glycol (PEG), Kanamycin ¹ , Neomycin ¹ etc)?	☐ No ☐ Yes: _____
6. Do you have a bleeding disorder, or are you receiving longer-term anticoagulation?	☐ No ☐ Yes: _____
7. If yes to question 6, is it well managed?	☐ No ☐ Yes ☐ NA
8. Have you ever felt faint or fainted after receiving a vaccine or medical procedure, or do you have a fear of injections/needles	☐ No ☐ Yes: _____

¹ Aminoglycosides related to Neomycin: Amikacin, Apramycin, Arbekacin, Framycetin, Gentamicin, Kanamycin, Netilmicin, Paromomycin, Rhodostreptomycin, Spectinomycin, Streptomycin, Tobramycin.

I have read the information about the influenza vaccine on the back of this consent form. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to _____ to administer the influenza vaccine.

Signature: _____ Date: _____

Are you consenting on behalf of someone else? ☐ No ☐ Yes

If yes, Legal Guardian full name: _____

Relationship: _____

Legal Guardian phone number: (_____) _____

For Clinic Use Only

I have used two client identifiers and the client has no contraindications to receiving the influenza vaccine based on the review of all screening questions.

Initials & Designation: _____

Vaccine:

<u>Age</u>	<u>Vaccine</u>	<u>Dosage and Route</u>	<u>Site</u>	<u>Lot Number and Expiry</u>
≥ 6 months of age	☐ Fluviral® (IIV3-SD, egg-based)	☐ 0.5 mL Intramuscular	☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh	
	☐ Fluzone® (IIV3-SD, egg-based)			
	Flucelvax® (IIV3-CC, cell culture-based)			Lot Number
≥ 65 years of age	☐ Fluad® (IIV3-Adj, egg-based)			
	☐ Fluzone® High-Dose (IIV3-HD, egg-based)			Expiry

Date & Time of Administration:

YYYY/MM/DDHH:MM

Signature & Designation:

Clinical notes (date and time):

Signature & Designation:

For Data Entry Use Only

☐ Data Entry in Panorama Complete

Signature: _____

Date: _____