Influenza / COVID-19 Consent Form

Reset Form

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Age

Personal Health Number	Address	City	Postal Code	Phone

Emergency Contact – Last Name	First Name	Emergency Phone Number

Answer questions in the appropriate box. Complete both Flu and COVID-19 Vaccines if receiving both vaccines.	Yes	No	N/A
Do you have a respiratory or active infection, fever, sudden cough, difficulty breathing, or other flu or COVID-19 like symptoms? If yes, re-book your appointment until you are well or as directed by your primary care provider.			
Do you take any medications affecting the immune system (e.g., steroids, immunosuppressants, antiviral drugs), or have chronic health conditions (e.g., cancer, leukemia), immune system problems, new/changing neurological disorders, bleeding disorders, or use blood thinners?			
Have you fainted or had a serious reaction to any previous medical procedure or vaccination including Guillain-Barré Syndrome (muscle weakness, difficulty walking steady, paralysis)?			
Do you have severe allergies to latex, food, medications, or components of a vaccine (e.g. eggs or egg products, gelatin, neomycin, gentamicin, formaldehyde, kanamycin, neomycin, polyethylene glycol, polysorbate, tromethamine, trometamol or tris)?			
Female only: Are you pregnant or breastfeeding, or planning to get pregnant or breastfeed within the next month?			
General Vaccine History			
Have you received any other vaccines in the past 4-8 weeks? If so, list:			
Have you received a **Tetanus** vaccine in the last 10 years?			
Individuals with chronic lung, kidney or heart disease, diabetes, smoke, or 65 years or older: Have you received a pneumonia vaccine such as **Pneumovax 23** or **Prevnar (13 or 20)**			
Individuals 50 years or older: Have you ever received a shingles vaccine such as **Zostavax** or **Shingrix**?			
Have you ever received a RSV vaccine such as **Arexvy or Abreysvo**?			
☐ Flu Vaccine			
Have you ever had a seasonal influenza vaccine before?			
Are you < 9 yrs. of age? Children < 9 yrs. of age and who have never received a flu shot, require 2 doses with a minimum spacing of 4 weeks between doses. Note: Children < 5 years of age will be immunized by public health. ☐ **First Dose** ☐ **Second Dose**			
☐ COVID-19 Vaccine			
Is this your first COVID-19 shot?			
Have you been diagnosed with Multisystem Inflammatory Syndrome in Children (MIS-C) or Adults (MIS-A) within the last 3 months?			
Do you have a history of myocarditis / pericarditis (inflammation of the heart or lining of the outside of the heart) OR have suffered from myocarditis or pericarditis after a previous dose of a COVID-19 vaccine?			

☐ I understand there may be some soreness, redness, and swelling at the injection site for a few days. Less common reactions include mild fever, chills, malaise, and/or muscle aches (flu-like symptoms) and may typically resolve within 2 to 3 days. As with any vaccine, hypersensitivity reaction is possible. This is rare, but may constitute itchiness, hives or swelling. Pattison Food Group Ltd. ("PFG") has provided me with information of other risks related to the vaccine. I request and authorize PFG, through its employees and contractors, to administer the vaccine by injection. I have read and understand the risks of the vaccination and I acknowledge that I have had an opportunity to ask questions which were answered to my satisfaction

☐ In return for the vaccination, I agree to release PFG (including its employees, directors, officers, and contractors) from any and all liability, claims, injury, damages, costs, expenses and compensation whatsoever, howsoever arising, from or in any way connected with the vaccination. I understand and agree to remain at the location for 15-30 minutes after the injection as directed by the pharmacist. In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary life-saving procedures as an interim measure until medical support personnel arrive. I have read and understand the above information.

Participant First/Last Name (Please Print)	Participant / Parent / Guardian Signature	Date (MM-DD-YYYY)

Immunizer's Name (Please Print)	Immunizer Signature	License #

Flu Vaccines	Lot#	Expiry Date	Other Vaccines	Lot#	Expiry Date
☐ Afluria® QIV (SQ) 0.5mL IM			☐ Arexvy® (GSK) 0.5mL IM		
☐ FluLaval Tetra QIV (GSK) 0.5mL IM			☐ Comirnaty® _____ (PFE) ____IM		
☐ Fluad® (SQ) 0.5mL IM			☐ Pneumovax-23 (MRK) 0.5mL IM		
☐ Flucelvax (SQ) 0.5mL IM			☐ Prevnar 20 (PFE) 0.5 mL IM		
☐ FluMist QIV LAIV (AZ) 0.2mL Nasal			☐ Shingrix®(GSK) 0.5mL IM		
☐ Fluzone® **High-Dose** (SP) 0.7mL IM			☐ Spikevax _____(MOD) ____IM		
☐ Fluzone® QIV 15mcg (SP) 0.5mL IM			☐		
☐ Influvac Tetra 0.5mL IM			☐		
Site: Arm ☐ Left ☐ Right		**Intranasal ☐**	**Site: Arm ☐ Left ☐ Right**		