FluShot

Influenza (Flu) Informed Consent

2021-2022 SEASON

Date (D/M/Y):	Name (Last Name, First Name):	
Provincial Health Number (PHN):		
Address:	City:	Postal Code:
Home Phone Number:	Mobile Number	Email:
Date of Birth (D/M/Y):	Age:	☐ Male ☐ Female

Flu Vaccine Questionnaire	Yes	No	Notes
Have you had the Flu Vaccine before?	☐	☐	
If you have had the flu shot before, have you ever had any reaction to the Flu Vaccine?	☐	☐	
Have ever you experienced difficulty breathing within 24 hours of getting a flu shot?	☐	☐	
Are you or do you think you might be pregnant?	☐	☐	
Do you have a history of Guillian-Barre Syndrome within 6 weeks of getting a flu shot?	☐	☐	

Allergies?

☐ None ☐ Latex ☐ Eggs ☐ Neomycin ☐ Formaldehyde ☐ Thimerosal

☐ Other(s):_____

Consent Given by Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the Flu Shot Fact Sheet. I have had the 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 clinic/pharmacy for 15 minutes after getting the flu shot.

☐☐I confirm that I or my child qualify for the publicly funded vaccine (based on the qualification stated on Sina Pharmacy's website https://mysina.ca/flushot for season 2021-2022).

☐ I confirm that I or my child want to receive the seasonal influenza vaccine

PUT YOUR APPOINTMENT DATE HERE

_____ _____ _____

Patient/Agent Name (& Relationship) Patient/Agent Signature Date Signed (D/M/Y)

HEALTH CARE PROVIDER'S DECLARATION: I confirm the above-named patient is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient. I am administering seasonal influenza vaccine no more than 21 days after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient.

_____ _____ _____

Health Care Provider's Signature Health Care Provider's License # Date Signed (D/M/Y)

Pharmacy Use Only

INFLUENZA VACCINE TO BE USED

Dosage: 0.5 mL

- ☐ FLUVIRAL® Public
- ☐ AGRIFLU® Public
- ☐ FLUAD® Public
- ☐ FLUZONE® HD Public
- ☐ FLUMIST® Quadrivalent Public
- ☐ FLUZONE® Quadrivalent Public
- ☐ INFLUVAC® Private
- ☐ AGRIFLU® Private
- ☐ FLUZONE HD® Private
- ☐ FLUZONE® Quadrivalent Private

Vaccine Lot#: _____

Site: Arm ☐ Left ☐ Right

Vaccine Expiry Date: (MM/YYYY): _____

Date of Immunization: (MM/DD/YYYY) ☐ Same as above

Time of Immunization: _____

Is the patient under 9 years of age? ☐ Yes ☐ No

*Children under 9 years of age who have never had a seasonal influenza vaccine need 2 doses. The second dose of vaccine should be given 4 weeks after the first dose.

EPINEPHRINE TREATMENT (if required)

- ☐ EPIPEN® (If weight is > 30 kg or 66 lbs)
- ☐ EPIPEN® Junior (If weight is between 15-30 kg or 33-66 lbs)

Number of Doses Administered:_____

Time(s) of Administration: (1)___ (2)___ (if applicable)

Health Care Provider's Signature:_____

Health Care Provider's License#:_____

Date & Time of Follow-up with Patient/Agent:

_____

COVID-19
Symptoms Screening Questionnaire

Screening Questions	YES	NO
Are you experiencing any of the following: • Severe difficulty breathing (e.g. struggling to breathe or speaking in single words) • Severe chest pain • Having a very hard time waking up • Feeling confused • Losing consciousness	☐ [1]	☐
Are you experiencing any of the following: • Mild to moderate shortness of breath • Inability to lie down because of difficulty breathing • Chronic health conditions that you are having difficulty managing because of difficulty	☐ [2]	☐
Are you experiencing cold, flu or COVID-19-like symptoms, even mild ones? Symptoms include: fever*, chills, cough or worsening of chronic cough, shortness of breath, sore throat, runny nose, loss of sense of smell or taste, headache, fatigue, diarrhea, loss of appetite, nausea and vomiting, muscle aches. While less common, symptoms can also include: stuffy nose, conjunctivitis (pink eye), dizziness, confusion, abdominal pain, skin rashes or discoloration of fingers or toes. *HealthLinkBC: • **Adults**: above 37.6°C (99.7°F) oral or axillary temperature or 38.1°C (100.6°F) rectal or ear temperature	☐ [3]	☐
Have you travelled to any countries outside Canada (including the United States) within the last 14 days?	☐ [4]	☐
Did you provide care or have close contact with a person with confirmed COVID-19? Note: This means you would have been contacted by your health authority's public health team.	☐ [5]	☐

If you answer YES to any of the above, please cancel your flu shot appointment and refer to the following for next steps:

[1] Please call 9-1-1 or go directly to their nearest emergency department right away. These symptoms require emergency medical care.

[2] Consult with your family doctor or nurse practitioner. You can call 8-1-1 anytime to talk to a nurse at HealthLinkBC and get advice about how you are feeling and what to do next. Monitor how you are feeling. If it becomes harder to breathe, can't drink anything or feel much worse, you must seek urgent medical care at an urgent care clinic or emergency department.

[3] Get a COVID-19 test and self-isolate. Testing is recommended for anyone, including children of any age with cold, flu or COVID-19-like symptoms, even mild ones. COVID-19 positive individuals will be contacted by public health and given further instructions.

[4] Self-isolate and self-monitor for symptoms for 14 days upon your arrival. This is mandatory under the Quarantine Act. Returning travelers who develop symptoms are also required to self-isolate for at least 14 days or 10 days after onset of symptoms, whichever is longer.

[5] Self-isolate and self-monitor for symptoms for 14 days since your last contact with the positive person.