Influenza Immunization Record

Last Name	First Name	Initial	Sex
Provincial Health Care Number		Date of Birth (yyyy-Mon-dd)	
Address		Phone (Home)	
City	Postal Code	Phone (Other)	

Please answer the following:

1. Do you have any of the following symptoms?

- Fever ☐yes ☐no
- Cough ☐yes ☐no
- Chills ☐yes ☐no
- Fatigue ☐yes ☐no
- Headache ☐yes ☐no
- Runny nose ☐yes ☐no
- Sore throat ☐yes ☐no
- Nasal congestion ☐yes ☐no
- Loss of appetite ☐yes ☐no
- Muscle/joint aches ☐yes ☐no
- Painful swallowing ☐yes ☐no
- Shortness of breath ☐yes ☐no
- Loss of taste/smell ☐yes ☐no
- Nausea/vomiting/diarrhea ☐yes ☐no
- Conjunctivitis (pink eye) ☐yes ☐no

2. Have you been in close contact with a confirmed case of COVID-19 in the past 14 days? ☐ yes ☐ no

****IF YOUR ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, YOU MUST RESCHEDULE****

3. Do you have any allergies? ☐ yes ☐ no If yes, please list:
4. Have you ever had a serious reaction to a vaccine? _☐ yes ☐ no
5. Do you have any autoimmune conditions, or do you take immunosuppressive medications? ☐ yes ☐ no
6. Have you ever had Guillain-Barre Syndrome (GBS)? ☐ yes ☐ no
7. Women: Are you pregnant or breastfeeding? ☐ yes ☐ no

- I understand that the pharmacist has received appropriate training and is registered to administer injections by the Alberta College of Pharmacists. I understand the pharmacist will comply with all professional standards surrounding the administration of injections as well as general pharmacy practice. The pharmacist maintains current certification in CPR and Basic First Aid.
- I agree to remain at the location for 15-30 minutes after the injection as directed by the pharmacist.
- The pharmacist has provided me with information on the vaccine being administered and the injection procedure so that I understand the expected outcome/reaction, as well as possible side effects.
- In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary lifesaving procedures as an interim measure until medical support personnel arrive.
- In case of emergency please contact emergency services at 911.
- I have read and understand the above information.

_ _____

Patient signature (parent or guardian if minor)

Influenza Vaccine (pharmacist use only)	
☑ Informed consent Reason Codes	Vaccine: ☐Fluzone Quadrivalent 0.5mL IM lot _____ exp ____ ☐Afluria Tetra 0.5mL IM lot P100353714 exp 06/22 ☐Fluzone HD 0.7mL IM lot UJ744AA exp 06/22 Site: Deltoid ☐ Left ☐ Right Ages 5-8: Previous influenza vaccine? ☐ Yes (Date: _____) ☐ No
☐ Ages 5-64 ☐ Ages 65+ Date Vaccine Given: _____	
Pharmacist's Name (printed)	**Pharmacist's Signature**