INJECTION INTAKE FORM, CONCENT &LIABILITY WAIVER

Stick Label Here

Carl's PHARMACY
Caring for Port Credit since 1932

Section 1: Patient Information (fill or Stick Fillware Label)

Last Name	First Name	Health Card #	Gendr

Phone Number	Alternate number	Date of Birth	Age

Address	City	Provc

Emergency Contact's Name	Emergency Contact's Phone #	Relationship

Section 2: Screening Questionnaire

	YES	NO
Are you, or have you been sick today, or within the past 3 days? (fever greater than 39.5°C, breathing problems, or active infection)		
Have you had difficulty breathing, wheezing or chest tightness within 24 hours of getting a vaccine?		
Are you allergic to any part of the influenza vaccine, or have you had a severe, life-threatening allergic reaction to		
Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to: • Contact lens solution • Egg •Arginine • Formaldehyde • Gelatin • Gentamicin • Kanamycin • Neomycin •Thimerosal•Polymyxin B		
Do you have a serious allergy to latex or natural rubber?		
Have you had a reaction to eggs or egg products but can still eat small amounts of egg? (eg. Stomach ache, skin reaction)		
Have you had Guillian-Barré Syndrome within 6 weeks of getting an influenza vaccine? Oculo-Respiratory Syndrome?		
Have you ever had a seizure or have an active, new, or changing brain/nervous system/neurological disorder?		
Do you have bleeding problems or use blood thinners? (eg. Warfarin)		
Are you pregnant, nursing, or do you intend to become pregnant?		
Have you received any vaccines in the last 4 weeks? If yes, please list.		
Do you have any of these medical conditions (Cancer, leukemia, HIV/AIDS) or take medications that weaken the		
Do you provide health care services to or do you have close contact with persons who are immunocompromised?		
Do you have severe asthma (on high dose inhaled or oral corticosteroids) or medically attended wheezing in the		
Have you received in the past 48 hours or do you intend to receive in the next 2 weeks flu antiviral therapy? (eg.		
For children under 18 years old: Is the child using, or will be using an aspirin/aspirin-containing therapy in the		

Section 3: General Liability Waiver,indemnification and hold harmless agreements,Consent Given By Patient/Agent:

I, the undersigned patient, parent or guardian, have read or have had explained to me information about the vaccine(s) beeing injected today ("Vaccine") as outlined on the Vaccine Fact Sheet (paper or online). I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the Vaccine. After getting the Vaccine, I agree to wait in the pharmacy for 15 minutes (or the time recommended by the pharmacist). I am aware it is possible (yet rare) to have an extreme allergic reaction to any component of the Vaccine. Serious and possibly fatal reactions called "anaphylaxis" can be life- threatening medical emergencies. Symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. If I experience such symptoms following vaccination, I am aware it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to treat this reaction and 9-1-1 will be called to provide additional assistance. In the event of anaphylaxis, I, my agent, and/or EMS paramedics will receive a copy of this form. I understand the information contained on this form, may be disclosed to the public health authority and to other required parties for the purpose of adverse event and drug safety reporting. This indemnification and hold harmless agreements shall include indemnity against all costs, including without limitation, attorney's fees and court costs, expenses, and liabilities incurred in or in connection with such claim or proceeding brought theron and in defense thereof.

Date	I confirm that I (or my child) want to receive the vaccine/injection	
	Signature	Patient/Agent Name (& Relationship)

PHARMACY USE ONLY

Section 4: Prescription Templates and Vaccine Used

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

Trivalent Flu Vacc	☐ **VAXIGRIP®** IM 0.5mL DIN02367718	☐**AGRIFLU®** IM 0.5ml DIN02346850	☐**INFLUVAC** IM 0.5ml DIN02269562	☐**FLUVIRAL®** 0.5ml IM DIN02420686	☐ **FLUZONE High-Dose** IM 0.5mL DIN02500523	☐ **FLUAD®**IM 0.5 mL DIN02362384	☐**INFLUVAC®** IM 0.5 mL DIN02269562

Tetravalent FLU Vaccine	**AFLURIA® TETRA** ☐ 0.5mL IM pre-filled syringe DIN02473283 ☐ 5mL IM multi-dose vial DIN02473313	**FLUCELVAX® QUAD IM** ☐ 0.5mL pre-filled syringe DIN02494248 ☐ 5mL multi-dose vial DIN02494248	**FLUZONE® QUAD** IM ☐ 0.5mL single-dose vial DIN02420643 ☐ 5mL multi-dose vial DIN02432730	☐ **INFLUVAC TETRA** 0.5mL IM DIN02484854	☐ **FLULAVAL TETRA** 0.5mL IM DIN02420783

Other Injections	☐ **SHINGRIX®** IM 0.5ml DIN 02468425 DOSE(**1**) DOSE(**2**)	☐ **PREVNAR-20®** IM 0.5mL DIN02527049	☐ **TWINRIX®** IM 0.5mL DIN02230578	☐ **AREXVY®** IM 0.5mL DIN02540207	☐ **PROLIA®** SC 0.5mL DIN02335204	☐ **Vit B12 IM** ----mls DIN00521515	☐ **COVID19 Pfizer/Mod.**

Date of Shot	**Time** of Shot	**Lot #:**	**Expiry:**	**Pharmacist Name & Signature(NICK)**	**License #(612348)OR**

Arm Admin site ☐**Right** ☐**Left**	Contacted Primary Prescriber: ☐**yes** ☑**No**, Patient to inform his doctor.	Emergency treatment: ☐**Yes** ☐**No**