	INJECTIO	N INTAKE FORM	И, CONCENT &L	IABILITY W	VAIVER						
Section	1: Patient Info	rmation (fill or	Stick Fillware L	abel)			Sti	ck Label He	ere		
Last Name		First Name	alth Card #		Gendr						
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Phone Num	lber	Alternate nur	nber	Date of Bir	rth	Age			1)		
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Emergener	Cantact's Nome	[	anna Contact's Dhans	. #	Deletionskin		PHA	RM	A(	'Y	
Emergency	Contact's Name	Ellier	gency Contact's Phone	: #	Relationship		Caring fo	or Port Credit sir	ce 1932 -		
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	u ever had a seiz	ure or have an a	ctive, new, or ch	nanging brai	in/nervous sys	tem/neur	ological dis	order?			
Do you h	nave bleeding pro	oblems or use bl	lood thinners? (e	g. Warfarin							
-			end to become p	-	-						
				-	+						
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 p	provide health ca	are services to or	r do you have clo	se contact v	with persons v	vho are im	imunocom	promised?			
Do you h	nave severe asth	ma (on high dos	e inhaled or oral	corticoster	oids) or medic	ally attend	ded wheezi	ing in the			
-		_	r do you intend t			-		_			
-		-	ild using, or will								
гог спша	iren under to ve	ars olu: is the ch	ind using, or will	be using an	- 450111117 450111	n-containi	ng therapy	in the			
			nnification and h						nt:		
Section 3	3: General Liabili	ty Waiver,inden		old harmles	ss agreements	Consent C	Given By Pa	itient/Agei		the	
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