CONSENT FOR Injectable INFLUENZA VACCINE

① CLIENT INFORMATION

Complete Sections 1, 2, and 3 **(Please Print)**

Last Name: _____ First Name: _____

Address: _____ Phone number: _____

Emergency Contact and Relation: _____ Emergency Phone number: _____

Personal Health Number _____ Date of Birth (DD/MM/YYYY) _____

Gender: ☐ Female ☐ Male ☐Transgender Pregnant: ☐No ☐Yes ☐N/A

COVID-19 pre-screen

Check if no symptoms

☐ 48 hours pre-injection

☐ time of injection

② CONSENT

☐ Client ☐ Parent ☐ Legal Guardian ☐ Representative

I understand the information in the HealthLink BC File(s) for the vaccine listed below. I understand the benefits and possible reactions of the vaccine and the risks of not getting immunized. I have been informed of any medical reason why the vaccine should not be given to me. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine listed below unless the consent is cancelled.

☐ I consent to receiving or for my child to receive the vaccine listed below.

☐ I will stay in the pharmacy for at least 15 minutes after the injection and seek medical attention if needed.

☐ I will report any adverse effects I experience to the immunizing pharmacist.

☐ I understand the information will be used and disclosed in accordance with the Freedom of Information and Protection of Privacy Act and that summary statistical information may be reported to the Ministry of Health.

R e l e a s e : In return for the vaccination, I agree to release Lu & Sons Enterprise Ltd. (Super Grocer & Pharmacy)—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.

③ OTHER HEALTH INFORMATION

☐ Your immune system is affected by a severe disease or medication. If checked, please specify: _____

☐ I have had a serious life-threatening allergic reaction to a vaccine/food/drug. Please specify: _____

☐ I have fainted during/after receiving a vaccine in the past.

☐ I have a history of Guillain-Barré syndrome (GBS) within 8 weeks of receipt of a previous dose of influenza vaccine without another cause being identified.

☐ I am receiving a CTLA-4 inhibitor (e.g. ipilimumab) alone or in combination with other checkpoint-inhibitiors for the treatment of cancer. Inactivated influenza vaccine should be given 8 weeks before starting treatment or 8 weeks after the last CTLA-4 inhibitor dose. For more specific details refer to the BC Cancer Influenza vaccine recommendations.

Name (PRINT): _____ Phone: _____

Signature: _____ Date signed: _____

FOR PHARMACIST USE ONLY

④ VACCINE INFORMATION

Name of vaccine _____ **DIN** _____

Dose _____ **mL** **Site:** ☐ **Left arm** ☐ **Right arm** **Route: IM / SC**

Lot#: _____ **Expiry date(YYYY/MM/DD)** _____

Pharmacy Label

⑤ PHARMACY INFORMATION

☐ **Flora Luk (11988)** ☐ **Cecille Chui (07745)** ☐ **Noel Lau (08820)**

☐ **Sam Lu (06326)** ☐ **Esther Fok (07759)** ☐_____

Pharmacist signature: _____

Date of administration (YYYY/MM/DD) _____ Time of administration _____

⑥ CLIENT RESPONSE

Before: Normal Yes ☐ No ☐ _____ **15-30 mins post-administration:** Normal Yes ☐ No ☐ _____

After: Normal Yes ☐ No ☐ _____ **Other comments:** _____

Faxed to Public Health Unit: Faxed to Dr. _____ ID# _____ Fax Number _____ Yes ☐

No ☐ Dear Doctor, this form is for your information and records. Thank you.