CONSENT FOR IMMUNIZATION

VACCINE for: ☐ COVID ☐ FLU ☐ Other
DATE:_____
DOSE___ OF ___(write 1 of 1 if not part of a series)

① CLIENT INFORMATION

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

Last Name 姓: _____

First Name 名: _____

Address 地址: _____

Phone number 電話號碼: _____

Emergency Contact and Relation 緊急連絡人姓名: _____

Emergency Phone number 緊急連絡人電話: _____

Personal Health Number 醫療卡號碼: _____

Date of Birth 出生日期 (DD/MM/YYYY) _____

Gender: ☐ Female ☐ Male ☐Transgender

Pregnant: ☐ No ☐ Yes ☐ N/A

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 the vaccine(s) listed below. _ OR _ ☐ for my child to receive the vaccine(s) 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.

Release: In return for the vaccination, I agree to release Lu & Sons Enterprise Ltd. & Sea Island Marketing Ltd.—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 received another vaccine in the last 4 weeks. Please specify: _____

For more specific details refer to the BC Cancer Influenza vaccine recommendations.

Name (PRINT): _____ Phone: _____

Signature 簽名: _____ Date signed: _____

FOR PHARMACIST USE ONLY

④ VACCINE INFORMATION

☐ **Spikevax** (Moderna) **BiV** L:
☐ **Comirnaty** (Pfizer) **MoV** L:
☐ **Comirnaty** (Pfizer) **BiV** L:
☐ _____
☐ **Fluzone QIV (6 m-64 y)** L:
☐ **Fluzone QIV Prefilled** L:
☐ **Afluria QIV (5-64 y)** L:
☐ **Fluad (65 years+)** L:
☐ **Fluzone High-Dose Quadrivalent**

DIN _____ **Dose** _____ **mL** **DIN** _____ **Dose** _____ **mL**

Lot#: _____ **Exp:** _____ **Lot#:** _____ **Exp:** _____

Site: LA / RA **Route: IM / / IN** **Site: LA / RA** **Route: IM / / IN**

Pharmacy Label

DIN _____ **Dose** _____ **mL**

Lot#: _____ **Exp:** _____

Site: LA / RA **Route: IM / / IN**

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:** _____