105-133 Baker Drive
Dartmouth NS B2W 0M6
Ph: 902-461-2244
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INJECTION CONSENT AND ADMINISTRATION FORM

Patient Name:__________________________ Phone Number:____________ Date of Birth:_____________________

Address:____

Health Card Number:__________________________ Physician Name:________________________ Fax:___N/A_____

Emergency Contact Name:_____________________________ Relationship:______________ Phone:______________

Please answer the following questions:

As of Today:	**Yes**	**No**
Is this the first time you are receiving this injection? (an influenza vaccine)		
Have you ever fainted or had a serious reaction to any previous injection or vaccine? *If yes, please describe the reaction:* ____________________		
Have you received any injections/vaccinations in the last 6 weeks?		
Do you have a fever, an active infection or feel unwell today?		
Are you allergic to: ___eggs ___Thimerosal (a preservative) ___latex ___medications (please specify) *If yes, please describe the reaction:* ____________________		
Do you have any chronic health conditions ***which may lower you immunity****? (eg. Asthma, diabetes, HIV, cancer)* *If yes, please list:* ____________________		
Are you currently on any medications/treatment ***that lowers your immunity****? (eg. Prednisone, radiotherapy, chemotherapy If yes, please list:* ____________________		
Do you have an active neurological condition (seizure disorder)?		
Do you have any bleeding disorders or are you taking any blood thinners?		
Have you had an infection of immunoglobulin or a blood transfusion within the last 3 months?		
If female, are you pregnant?		

Medication/Vaccine Administered	**Dose**	**Purpose**	**Date/Time Given**	**Route**	**Site**	**Side**	**Lot**	**Exp**	**COMMENTS / OBSERVATIONS**
	0.5 ml	Influenza vaccine		IM	Deltoid	R L			

- I understand the information provided to me regarding the benefits, side effects, and risks (including risks of not receiving the vaccine) associated with the vaccine being administered today.
- I have had the opportunity to have my questions answered.
- I/my dependent, agree to **remain at the pharmacy/site for at least 15 minutes following** administration of the vaccine or as directed by the pharmacist.
- I authorize the pharmacist to administer epinephrine and/or life-saving procedures in the event of a severe allergic reaction.
- I authorize the pharmacist to notify my physician of the vaccine received
- **I herby consent** to receive the vaccine indicated above today, and release this pharmacy and the administering pharmacist/healthcare professional from any and all liability.
- **I confirm that I have no symptoms suggestive of COVID-19, have not been in contact with anyone known or suspected to have COVID-19, and have not travelled outside the Atlantic Provinces within the last 14 days.**

Patient/Guardian Signature: ________________________________ **Date:** ____________________**,2020**____

Pharmacist Name: _________**Heather Piccott**_________________ **License Number:** ____**2805**__________

Pharmacist Signature: ________________________________ **Date:** ____________________**,2020**____