Remedy's Rx® The Local Drug Store™

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2025 - 2026 Seasonal Influenza (Flu) Vaccine Consent Form

PATIENT INFORMATION			
Last Name:	**First Name:**	**Personal Health Number (PHN):**	
Phone Number:	**Gender:** ☐ **Male** ☐ **Female** ☐ **X or Non-Binary** ☐ **Other**	**Age:**	**Date Of Birth: (DD-MM-YYYY)**

SCREENING QUESTIONNAIRE	YES	NO
Are you, or have you been **sick within the past 3 days?** (Fever greater than 38°C, breathing problems or active infection) TEMPERATURE: _____		
Have you had **difficulty breathing, wheezing or chest tightness** within 24 hours of getting an influenza vaccine?		
Are you **allergic** to any part of the influenza vaccine, or have you had a severe, life-threatening allergic reaction to a past influenza vaccine?		
Are you allergic (eg. Wheezing, chest tightness, difficulty breathing, hives) to: **•Contact lens solution •Egg or egg products •Formaldehyde •Gelatin •Gentamicin •Kanamycin •Neomycin •Thimerosal**		
Do you have a serious allergy to **latex** or **natural rubber?**		
Have you had **Guillian-Barre Syndrome** (eg. Muscle weakness, tingling sensation, difficulty with facial movement) **OR Oculo-Respiratory Syndrome** (eg. Bilateral red eyes, wheezing, chest tightness, difficulty swallowing) within 6 weeks of getting an influenza vaccine?		
Do you have an active, new, or changing **neurological disorder**? Have you ever had a **seizure**?		
Do you have **bleeding problems** or use **blood thinners?** (eg. Warfarin, low dose or regular strength Aspirin)		

CONSENT GIVEN BY PATIENT/AGENT

I, the undersigned patient, parent, or guardian, have read or have had explained to me information about the seasonal influenza vaccine ("Vaccine") as outlined on the Flu Vaccine Fact Sheet. 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, I agree to wait in the clinic/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 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.

☐ **I confirm that I want to receive the Vaccine OR** ☐ **I confirm that I want my child to receive the Vaccine**

Patient/Agent Name (& Relationship)	**Patient/Agent Signature**	**Date Signed**

PHARMACY USE ONLY

☐ **65 years of age and older (PIN 00000050)**	**Trivalent Influenza Vaccine Adjuvanted (TIV-Adj)** ☐ **Fluad® 0.5mL IM** **DIN: 02362384 LOT: 407286 EXP: 25 JUNE 2026**	**Site of Administration:** ☐ **Left Arm** ☐ **Right Arm**
☐ **5 to 64 years of age (PIN 05666650)**	**Standard Dose Trivalent Influenza Vaccine (SD-TIV)** ☐ **Fluzone® 0.5mL IM** **DIN: 02365707 LOT: U8834AA EXP: 30 JUNE 2026**	

For patients below 9 years old and have never received a dose of seasonal influenza vaccine, please administer 2 doses with a minimum spacing of 4 weeks between doses

☐ **First dose administration** _____ ☐ **Second dose administration** _____

Pharmacist Name/Signature	**Time of Immunization**	**Date of Immunization**