RxPharmaChoice
CONSENT FOR VACCINE ADMINISTRATION

Patient Name: _____ **Date of Birth:** _____

Provincial Health#: _____ **Phone#:** _____

Address: _____

Emergency Contact: _____ **Phone#:** _____

Please answer the following questions:	**YES**	**NO**
1. Have you received a vaccine before? If yes, when:		
2. Have you had COVID-19 Infection in the last 6 months? If yes, when:		
3. Are you sick today? (e.g. ***fever***, *common cold, infection*)		
4. Do you have any allergies? (e.g. *latex, eggs, gelatin, antibiotics*)		
5. Do you have any health conditions?		
6. Do you have any conditions or take medication which may compromise your immune system?		
7. Do you have any bleeding disorders or take blood thinners?		
8. Have you had a reaction to a vaccine in the past? (e.g. *Allergic Reactions or Guillain-Barre Syndrome*)		
9. Do you have a history of Myocarditis or Pericarditis?		
10. Are you pregnant, trying to conceive or breastfeeding?		
11. Do you have Lymphatic circulation impairment? (e.g. *axillary lymph node removal, lymphedema, amputation*)		
12. Have you ever felt faint or fainted after a previous vaccine or medical procedure?		

Informed Consent

- I agree to remain at the location for 15 minutes or for the duration specified/directed by the Pharmacist.
- I have had a chance to ask questions and have the questions answered. I am aware of the benefits and risks of vaccination.
- In the event of an emergency, I authorize the Pharmacist to administer epinephrine and/or perform any necessary lifesaving procedures until medical support arrives. In case of an emergency, please contact my emergency contact.
- I understand that the Pharmacist will comply with all professional standards for administering injections. I acknowledge that the Pharmacist has discussed the risks and benefits of receiving this injection with me and has answered my questions.
- I confirm that I have the legal authority to consent to this immunization.
- I agree to be injected intramuscularly/subcutaneously with this immunization.

Patient Signature (or Guardian): _____ **Date:** _____

Vaccine Name	**Lot #** **Expiry Date**	**Site**	**Route**	**Dosage**	**Date** **Time**	**Signature of Immunizer**
Fluzone HD	*U8165BA* *30JUN24*	Left Arm ☐ Right Arm ☐	IM	0.7 mL		
Fluzone	*U8046DA* *30JUN24*	Left Arm ☐ Right Arm ☐	IM	0.5 mL		
Pneumovax		Left Arm ☐ Right Arm ☐	IM	0.5 mL		
FluMist	*TJ2292* *17JAN2024*	Intranasally	Intranasally	0.1 mL (in each nostril)		
Pfizer(COVID)	*HJ3097* *31/01/2025*	Left Arm ☐ Right Arm ☐	IM	0.3 mL		
Moderna(COVID)	*041G23A* *27/08/2024*	Left Arm ☐ Right Arm ☐	IM	0.5 mL		
		Left Arm ☐ Right Arm ☐	IM ☐ SC ☐			