Screening Questionnaire and Consent Form for Immunizations

Section 1: Personal Information

Patient First & Last Name:		Patient Telephone:	
Patient Home Address:		Patient OHIP No.:	
☐ Male ☐ Female ☐ Other	Age:	Weight: kg or lb.	Date of Birth (DD/MM/YYYY) / /
Name of Emergency Contact:		Contact's Daytime Phone Number:	
Emergency Contact's Relationship to Patient:		Contact's Alternate Phone Number:	

Section 2: Screening Questionnaire

For adult patients as well as parents of children (≥ 5years) to be vaccinated:

The following questions will help us determine if there is any reason you or your child should not get a vaccine today. If you answer "yes" to any question, it does not necessarily mean the shot cannot be given. However, additional information may be required.

This questionnaire is general in nature. The pharmacist may ask additional questions that may be more specific to the vaccine(s) you or your child will be receiving.

If a question is not clear, please ask your pharmacist to explain it.

Please answer the following questions	Yes	No	Unsure	Action required
Are you **sick today**? (fever greater than 39.5°C, breathing problems, or active infection)	☐	☐	☐	If YES, do NOT get vaccinated today
Are you **allergic** to any medications including vaccines?	☐	☐	☐	If YES, please list your medication allergies here:
Have you ever had a **severe, life threatening reaction** to a vaccine, or have you experienced **wheezing**, **chest tightness**, or **difficulty breathing** within 24 hours of having a vaccine?	☐	☐	☐	If YES or UNSURE, do NOT get vaccinated & SPEAK WITH YOUR PRIMARY CARE PROVIDER
Have you had a reaction to **eggs or egg products** but can still eat small amounts of egg? (e.g. stomach ache, skin reaction)	☐	☐	☐	If YES or UNSURE, you can receive vaccine but MUST BE OBSERVED FOR 30 MINUTES AFTERWARDS
Do you have any **serious allergy** to latex or natural rubber?	☐	☐	☐	If YES or UNSURE, you can receive vaccine but non-latex materials are to be used
Do you have a **new or changing** neurological disorder?	☐	☐	☐	If YES, do NOT get vaccinated & SPEAK WITH YOUR PRIMARY CARE PROVIDER
Do you have **bleeding problems or use blood thinners**? (e.g. warfarin, low dose or regular strength aspirin)	☐	☐	☐	If YES, the vaccine can be given but gentle pressure should be applied to the injection site immediately afterwards
Have you ever experienced adverse events (**fainting, nausea, vomiting**) following a vaccine?	☐	☐	☐	If YES, you should be vaccinated lying down and should remain lying down for approximately 5 minutes
For live vaccines: Are you **pregnant** or **breast feeding**?	☐	☐	☐	If YES, your pharmacist will check whether you can receive the vaccine.
For live vaccines: Do you have any **acute or chronic immunocompromising diseases or conditions**, or do you take any medications that affect your immune system?	☐	☐	☐	If YES, your pharmacist will check whether you can receive the vaccine.
Have you received any other vaccines within the past 4 weeks?	☐	☐	☐	If YES, please list the vaccine(s) received:

Note: If multiple vaccines are to be administered, sections 1 and 2 need only be completed once. However, sections 3, 4 and 5 (page 2) should be completed separately for each vaccine administered.

This tool has been created to identify potential concerns or contraindications prior to immunization of any vaccine. However, it is the responsibility of the pharmacist to assess the specific vaccine to be injected and ensure any necessary action is taken before administration.

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Section 3: Patient/Agent Consent

I, the undersigned client, parent or guardian, have read or had explained to me information about the vaccine as outlined in the vaccine information sheets provided to me. 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 pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the vaccine.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and is a medical emergency. If I experience such a reaction following vaccination, I am aware that I may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 9-1-1 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips.

In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐ **I confirm that I want to receive**

[pharmacist to indicate vaccine name]

OR

☐ **I confirm that I want my child to receive**

[pharmacist to indicate vaccine name]

Patient/Agent Name (& Relationship)	**Patient/Agent Signature**	**Date Signed** (DD/MM/YYYY): / /

PHARMACIST DECLARATION: I confirm the above named patient is capable of providing consent for receiving *[pharmacist to insert vaccine name]* and that *[pharmacist to insert vaccine name]* should be given to the patient.

Pharmacist Signature:	**OCP Number:**	**Date Signed** (DD/MM/YYYY): / /

Section 4: Prescription Templates – Pharmacy Use Only

VACCINE		**IN CASE OF EMERGENCY TREATMENT**	
Patient First and Last Name:			
VACCINE NAME:		☐ EpiPen® Regular 0.3MG/0.3ML – DIN 00509558	
DIN:		☐ EpiPen® Junior 0.15MG/0.3ML – DIN 00578657	
		☐ Diphenhydramine – Dosage: DIN	
NUMBER OF DOSES TO RECEIVE: ☐ 1 ☐ 2 ☐ 3		☐ 2nd Generation Antihistamine – Product Name: Dosage: DIN	
Vaccine Lot Numbers: 1: 2: 3:	Expiry (MM/YYYY): 1: 2: 3:	Number of Doses Administered:	
Date(s) of Immunization **(DD/MM/YYYY)** 1. / / 2. / / *(if applicable)* 3. / / *(if applicable)*	Time(s) of Administration: 1. 2. *(if applicable)* 3. *(if applicable)*	Date of Administration: **(DD/MM/YYYY)** 1. / / 2. / / *(if applicable)* 3. / / *(if applicable)*	Time(s) of Administration: 1. 2. *(if applicable)* 3. *(if applicable)*
Dose: / Route: ☐ **IM** ☐ **SC** ☐ **ID**	Site of administration: ☐ Left: _____ ☐ Right: _____	Date of Follow-up with Patient/Agent:	Time of Day of Follow-up with Patient/Agent:
Administering Pharmacist Name:	OCP Number:	Administering Pharmacist Name:	OCP Number:
Administering Pharmacist Signature:		Administering Pharmacist Signature:	

Section 5: Pharmacist Observation Notes (including additional emergency measures taken)