

## SEASONAL INACTIVATED INFLUENZA VACCINATION SCREENING AND CONSENT FORM

Please complete this form and read the section entitled "Preparing for the Flu Shot" before receiving the seasonal inactivated influenza vaccine ("flu shot"). Your answers to these questions will help the pharmacist determine if there is any reason why you should not receive this vaccine. If you are a parent or guardian providing consent for a child or other person, please complete this form for the person being vaccinated.

### Patient Information

|                |                   |            |
|----------------|-------------------|------------|
| First Name:    | Last Name:        |            |
| Date of Birth: | Age:              | Sex: M / F |
| Address:       |                   |            |
| Health Card #: | Telephone Number: |            |

### Screening Questionnaire for Person to be Vaccinated

|   | Yes | No |
|---|-----|----|
| Are you sick today (i.e., fever greater than 39.5°C, breathing problems, active infection)?   |     |    |
| Do you have an allergy to eggs or egg products?   |     |    |
| Do you have an allergy to any of the components of the flu vaccine (e.g., gentamicin, neomycin, kanamycin, thimerosal, formaldehyde)? |     |    |
| Do you take a blood thinner or have a bleeding disorder?  |     |    |
| Have you had a serious reaction to influenza vaccine in the past?   |     |    |
| Do you have a new or changing condition affecting the brain or nervous system?  |     |    |
| Have you ever had Guillain-Barré syndrome?  |     |    |

### Seasonal Inactivated Influenza Vaccination Patient/Agent Consent

I consent to having the Shoppers Drug Mart Pharmacist administer the seasonal inactivated influenza vaccine. I have reviewed the document entitled "Preparing for the Flu Shot" and the pharmacist has answered my questions. I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the pharmacy for 15 to 30 minutes after receiving the vaccination. I agree to see a doctor if I develop any side effects or health problems after receiving the vaccine. I agree that the Shoppers Drug Mart pharmacy may share my personal health information regarding this vaccination as required with public health officials and other healthcare providers.

- I am providing consent for myself
- I am providing consent for the patient identified above. *Contact information of patient agent, if applicable:*

\_\_\_\_\_

Relationship to person receiving the seasonal inactivated influenza vaccination:

- Parent       Guardian       Other, please specify \_\_\_\_\_

Name of person providing consent: \_\_\_\_\_

Signature of person providing consent: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
          mm        dd        year

I confirm that the patient named above is capable of providing consent for the seasonal influenza vaccination or that a parent/ guardian or other agent has provided consent on behalf of the patient. I confirm that the seasonal influenza vaccine should be given to the patient based on my assessment.

Name and Title of Pharmacist Administering Vaccine: \_\_\_\_\_

Pharmacist Licence Number: \_\_\_\_\_ Signature: \_\_\_\_\_

## PREPARING FOR THE FLU SHOT

### What is influenza?

Influenza (“the flu”) is an infection of the respiratory tract that is caused by a virus. It is spread through coughing, sneezing, shaking hands or by touching contaminated objects. Symptoms include sudden high fever, cough, headache, muscle aches, loss of appetite and fatigue. Flu season in Canada usually lasts from November to April.

### Why get the flu shot?

It can not only prevent you from getting ill, but also from spreading influenza to those who may be at risk of more serious complications, such as pneumonia. Getting a flu shot every year is an important part of your defense against influenza because the type of virus changes from year to year.

### Who should get it and who should not get it?

It is recommended that everyone 6 months of age and older get the flu shot. You should speak with your doctor first if you have a severe egg allergy, a history of a severe allergic reaction to influenza vaccine or a component of the vaccine, or a history of Guillain-Barré syndrome because the flu shot may not be appropriate for you. If you are ill with a fever, the pharmacist may ask you to come back for your flu shot when you are better.

### What can I expect from the flu shot?

The injection is usually given in the arm so the pharmacist will require access to your upper arm. The flu shot does not cause the flu. The most common side effect is soreness at the site of the injection. Some people can also develop a fever and muscle aches. The pharmacist will ask you to wait at the pharmacy for approximately 15 minutes after your injection to make sure that you do not have a reaction to the vaccine.

### What should I do if I experience a side effect or reaction from the flu shot?

For soreness, ask the pharmacist if an over-the-counter pain medication may be appropriate for you, or apply a cold cloth to the area. If you experience a less common reaction such as red eyes, breathing problems, and swelling of the face (called oculorespiratory syndrome) see your doctor if these symptoms do not go away. Guillain-Barré syndrome is rare and causes symptoms such as muscle weakness, tingling and numbness in the legs and feet or loss of movement. If you are concerned about your symptoms, see your doctor.

### Pharmacy Use Only – Pharmacist Documentation

|   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| Influenza vaccine given   | <input type="checkbox"/> Agriflu®<br>(Novartis)<br>DIN: 02346850  | <input type="checkbox"/> Fluvad®<br>(Novartis)<br>DIN: 02362384 | <input type="checkbox"/> Fluviral®<br>(GSK)<br>DIN: 02015986          | <input type="checkbox"/> Fluzone®QIV<br>(sanofi pasteur)<br>DIN: 02420643 | <input type="checkbox"/> Influvac®<br>(Abbott)<br>DIN: 02269562 | <input type="checkbox"/> Other _____<br>Manufacturer: _____<br>DIN: _____ |
| Date of administration:                      mm                      dd                      year |   |   | Time of administration: _____ AM / PM                                 |   |   |   |
| Dose: <input type="checkbox"/> 0.5 mL <input type="checkbox"/> _____                              |   |   | Route and site of administration: <input type="checkbox"/> IM         |   |   |   |
| [NS only] Dose number in series, if applicable: _____   |   |   | Deltoid: <input type="checkbox"/> Right <input type="checkbox"/> Left |   |   |   |
| Lot number:   |   |   | Expiry Date:  |   |   |   |
| Rationale for vaccination   | <input type="checkbox"/> Prevention of influenza; no contraindications<br>Other comments:   |   |   |   |   |   |
| Patient counseling  | <input type="checkbox"/> Potential adverse reactions and their management<br><input type="checkbox"/> Other:  |   |   |   |   |   |
| Patient response  | Before vaccination administration/vaccination:<br>During administration:<br>After waiting period:   |   |   |   |   |   |
| Adverse reactions   | Did the patient have an adverse reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><i>(If yes, describe nature of the reaction and action(s) taken)</i>  |   |   |   |   |   |
| Follow-up   | <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, describe the reason for follow-up and timing)</i>  |   |   |   |   |   |
| Communication   | <input type="checkbox"/> Public Health <input type="checkbox"/> Healthcare provider    Name: _____<br>Method of notification: <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Other: _____<br>Date notified: _____ |   |   |   |   |   |

## FLU IMMUNIZATION RECORD

AFFIX PHARMACY LABEL HERE

FLU VACCINE NAME:

Agriflu       Flud       Fluviral

Fluzone       Influvac

\_\_\_\_\_

If applicable, next dose due date:

\_\_\_\_\_

### AFTER FLU SHOT CARE

By getting your flu shot today, you've done your part to protect yourself, your loved ones and your community from the spread of influenza. Please take a moment to review the following information

#### What should I do if I experience a reaction?

The flu shot is well tolerated and most people will have no reaction or only a mild reaction, so you should be able to go about your normal activities for the rest of the day. The following are potential side effects and suggestions to help manage them:

- Soreness at the injection site – Apply a cool compress to the site (10 minutes on and 10 minutes off) until the soreness goes away.
- Mild fever and muscle aches – If needed, ask your Pharmacist to recommend an over-the-counter medication

#### Why do I need to stay at the Pharmacy for 15 minutes after getting my flu shot?

In very rare instances, a serious allergic reaction can occur. These reactions most often begin shortly after receiving the vaccination but may appear a few hours later as well. Symptoms may include any of the following and require immediate medical attention:

- Face, mouth, throat swelling
- Hives, itchy rash
- Chest pain, increased heart rate, difficulty breathing
- Sudden decrease in blood pressure, dizziness, confusion
- Crampy abdominal pain, nausea, vomiting, diarrhea

In addition, if any unusual condition occurs following vaccination, such as a high fever (over 38°C), severe muscle aches or tingling or numbness in the legs, seek medical attention right away.

#### How long does it take for the flu shot to become effective?

It takes about 2 weeks after your flu shot for your body to build antibodies, and therefore, you may not have added protection from the flu during this time.

**For more information, speak to your Shoppers Drug Mart Pharmacist.**