CONSENT FOR VACCINE AND IMMUNIZATION RECORD

Have you ever had a severe reaction to a vaccination that required medical attention? (eg.anaphylaxis/fainting/hives/shock/Guillain-Barre Syndrome/ Oculo-respiratory Syndrome)	Y	N
Have you received any vaccinations in the past 6 weeks?	Y	N
Do you have a fever, diarrhea, vomiting, or active cold today? Defer vaccine.	Y	N
If female, are you pregnant or planning to become pregnant or breastfeeding?	Y	N
Do you have an allergy to eggs or egg protein or gelatin?	Y	N
Do you have any allergies to any food or medication?	Y	N
Are you taking any blood thinners? (eg.warfarin, ASA, clopidogrel,apixaban)	Y	N
Are you currently taking beta-blockers such as Atenolol, Propranolol, Metoprolol, etc.?	Y	N
Do you have any immunological, neurological or blood disorders? (eg. history of immunosupression, HIV, chemotherapy or radiation, excessive bleeding or thrombocytopenia)	Y	N
Are you currently taking 20mg or more of Prednisone daily?	Y	N
Do you have an allergy to latex (dry natural rubber)?	Y	N
Have you had Shingles within the past 12 months?	Y	N
Are you currently taking anti-viral medications (eg. Famcyclovir,Acyclovir, Valacyclovir,)	Y	N

If you answered YES to any of the questions, please discuss with pharmacist BEFORE vaccination.

May we contact your family doctor to advise of vaccine administration, or if need arises?	Y	N
I have read or had explained to me the HealthLinkBC File information on this vaccine.	Y	N

A registered pharmacist, certified in injection administration, will administer the vaccine.
Epinephrine 1:1000 will available in case of allergic reaction.
You agree to remain in the pharmacy for 20 minutes post vaccination. (Very rarely, severe reactions such as hives, difficulty breathing and swelling of lips and tongue can occur)

I consent as: ☐ **the Client,** ☐ **a Parent,** ☐ **a Legal Representative,** ☐ **a Guardian** to the Client named below to receive the following vaccine(s):

☐**Seasonal flu** ☐**Prevnar-13** ☐**Pneumovax-23** ☐**ZostavaxII** ☐**Shingrix** ☐**Other**_____

In so consenting, I waive any claim for damages that I (or anyone claiming on my behalf) may have against any parties involved in administering the vaccine on account of injury or misfortune the Client may suffer as a result of the vaccine.

Client Name (print): _____ **Date:** _____

Client signature: _____ **Family Doctor:** _____

BC Care Card Number: _____ **Birth Date:** _____

Address: _____ **Telephone #:** _____

FOR PHARMACY USE ONLY:

Vaccine Received: _____ **Dose:** _____ **Site:** _____ **Route:** _____

Manufacturer: **DIN:** **Lot number:** _____ **Expiry:** _____

Pharmacist Name: _____ **Lic#:** **Date:** _____