# Face Mask Stock Illustrations, Cliparts And Royalty Free Face Mask Vectors

 FaFace mask/covering **MANDATORY** for this service

#  (please provide your own)

# CONSENT FOR IMMUNIZATION

❶ **CLIENT INFORMATION** (please print)

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| --- | --- | --- |
| Last Name: | First Name: | Date of Birth (YYYY/MM/DD): |
| Address: | Telephone Number: |
| Emergency Contact and Relation: | Emergency Telephone Number: |
| Personal Health Number: | Sex: Female  Male  Other:\_\_\_\_\_\_\_\_\_\_\_ | Pregnancy Status: No  Yes  N/A |

❷ **OTHER HEALTH INFORMATION** (please check all that apply √):

* My immune system is affected by a severe disease or medication. Please specify:
* I have had a serious life-threatening allergic reaction. Please explain:
* I have known allergies to medicines/others (i.e. latex). Please list all:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I am allergic to Thimerosol (product used in contact lens solution)
* I am allergic to chicken, eggs, or egg products (many vaccines contain these)
* I have had a reaction to the flu shot in the past. Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I have received another vaccine in the last 4 weeks. Please specify:

❸ **CONSENT**  Client  Parent  Legal guardian  Representative

The patient was provided and understood the information from HealthLink BC File(s) for the vaccine listed below. They understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. They have been informed of any medical reason why the vaccine listed below should not be given to them/their child, if any. They have had the opportunity to ask questions that were answered to their satisfaction. They gave their consent voluntarily and understand that this consent is valid for the vaccine listed below unless the consent is cancelled.

* They consent to receiving/their child to receive the vaccine listed below.
* They agree to wait outside the pharmacy for at least 15 minutes after the injection before leaving, and seek medical attention if needed.
* They agree to report any adverse effects they experience to the immunizing pharmacist.

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| --- | --- |
| **Name** of Person Providing Consent: | **Telephone Number** (if different from above): |
| **Signature** of Person Providing Consent: |
| Pharmacy Staff (who obtained consent): | Date Consent Obtained (YYYY/MM/DD): | Time Consent Obtained: |

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| --- |
| **FOR PHARMACIST USE ONLY** |
| ❹ **VACCINE INFORMATION**Name of vaccine: DIN: Dose: mL Site: LA / RA Route: IM / SC / ID / IN Lot #: Expiry date (YYYY/MM/DD): LA left arm; RA right arm; IM intramuscular; SC subcutaneous; ID intradermal; IN intranasal. | Pharmacy Label |
| ❺ **PHARMACY INFORMATION**Pharmacist signature: Licence number: Date of administration (YYYY/MM/DD): Time of administration:  |



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 **(please provide your own)**

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| **If YES to any of the following, advise pharmacist immediately** | **Yes** | **No** |
| Are you experiencing any of the following:* Severe difficulty breathing (e.g. struggling to breathe or speaking in single words)
* Severe chest pain
* Having a very hard time waking up
* Feeling confused
 |  |  |
| Are you experiencing any of the following: * Mild to moderate shortness of breath
* Inability to lie down because of difficulty breathing
* Chronic health conditions that you are having difficulty managing because of difficulty breathing
 |  |  |
| Are you experiencing cold, flu or COVID-19-like symptoms, even mild ones?Symptoms include: fever\*, chills, cough or worsening of chronic cough, shortness of breath, sore throat, runny nose, loss of sense of smell or taste, headache, fatigue, diarrhea, loss of appetite, nausea and vomiting, muscle aches.While less common, symptoms can also include: stuffy nose, conjunctivitis (pink eye), dizziness, confusion, abdominal pain, skin rashes or discoloration of fingers or toes.  |  |  |
| Have you travelled to any countries outside Canada (including the US) within the last 14 days? |  |  |
| Did you provide care or have close contact with a person with confirmed COVID-19?Note: This means you would have been contacted by your health authority’s public health team. |  |  |
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| **FOR PHARMACIST USE ONLY** |

**Is temperature (forehead) within normal range?*** **Adults**: fever above approx. 37.6°C (99.7°F) oral or axillary temperature
* **Children**: fever above approx. 37.6°C (99.7°F) axillary temperature
 | \_\_\_\_\_\_°C |  |

Please select all that apply:

* You are planning on or may be visiting a health care facility in the next year (doctor’s office, pharmacy, senior’s home, hospital, etc)
* You are or may be in contact with children under 5 years of age in the next year (including in a school, daycare, or caregiver capacity)
* You are or may be in household contact with someone from a high risk population (>65 years old, indigenous, pregnant, etc) in the next year
* You are or may become pregnant/start breast feeding during the influenza season
* You currently satisfy or may satisfy other high risk population criteria:
	+ You are >65 years of age, indigenous, have swallowing issues, or have chronic conditions such as asthma, COPD, diabetes, hypertension, weakened immune system or kidney disease
* You are a child aged 6 to 59 months
* You are an adult 65 years and older
* You are between the ages of 5 and 64 years with qualifying medical conditions (asthma, COPD, diabetes, hypertension, weakened immune system or kidney disease, etc)
* You are capable of transmitting influenza to those at high risk (children, elderly, immunocompromised patients, etc)
* You are an essential service provider (such as fire fighter, police, etc)