Ontario Pharmacists' Association

Screening Questionnaire – For Inactivated Injectable Influenza Vaccine

Section 1: Personal Information

Patient First & Last Name:			Patient Telephone: ______-______-________
Patient Address:			Patient OHIP No:
☐ Male ☐ Female	Age: ____	Child's Weight: ____ kg or ____ lb	Date of Birth (MM/DD/YYYY) _____/____/_____

Name of Emergency Contact:	Contact's Daytime Phone Number: _____-_____-________
Emergency Contact's Relationship to Patient:	Contact's Evening/Other 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 we should not give you or your child the flu shot today. If you answer "yes" to any question, it does not necessarily mean the shot cannot be given. It simply means additional questions must be asked.

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

PLEASE ANSWER THE FOLLOWING QUESTIONS	YES	NO	UNSURE	ACTION REQ'D
Are you **sick today**? (fever greater than 39.5°C, breathing problems, or active infection)				If YES, do NOT get the shot today
Are you **allergic** to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?				If YES or UNSURE, do NOT get the shot & SPEAK WITH YOUR MD/NP
Have you had **wheezing, chest tightness or difficulty breathing** within 24 hours of getting a flu shot?				
Have you had a severe reaction to **eggs or egg products**? (e.g. wheezing, chest tightness, difficulty breathing, hives)				
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 flu shot but MUST BE OBSERVED FOR 30 MINUTES AFTERWARDS
Have you had **Guillain-Barré Syndrome** within 6 weeks of getting a flu shot?				If YES, do not get the flu shot
Do you have a **new or changing** neurological disorder?				If YES, do not get the flu shot & SEE YOUR MD
Do you have **bleeding problems or use blood thinners**? (e.g. warfarin, low dose or regular strength aspirin)				If YES, shot CAN be given but apply gentle pressure afterwards

Seasonal Influenza Vaccine – Consent Form & Rx Template 2012-13

Section 3: Consent Given By Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the Flu Shot Fact Sheet. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the flu shot. I agree to wait in the clinic for 15 minutes (or time recommended by the pharmacist) after getting the flu shot.

☐ **I confirm that I want to receive the seasonal influenza vaccine.**

OR

☐ **I confirm that I want my child to receive the seasonal influenza vaccine.**

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

PHARMACIST DECLARATION: I confirm the above named patient is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient. I am administering seasonal influenza vaccine no more than 21 days after the consent was signed by the Guardian or Committee, Representative, or Temporary Substitute Decision Maker of the patient.

_______________	_______________	_______________
Pharmacist Signature	**OCP License #**	**Date Signed (MM/DD/YYYY)**

Section 4: Prescription Templates – Pharmacy Use Only

INFLUENZA VACCINE TO BE USED	EPINEPHRINE TREATMENT
☐ AGRIFLU® ....DIN 02346850	☐ EPIPEN®.................... PIN 09857423 (If weight is ≥ 30 kg or 66 lbs)
☐ VAXIGRIP® ....DIN 02223929	☐ EPIPEN® Junior ....PIN 09857424 (If weight is between 15-30 kg or 33-66 lbs)
☐ FLUAD® ....DIN 02362384	Number of Doses Administered:_______
☐ FLUVIRAL® ....DIN 02015986	Time(s) of Administration: (1) _______ (2) _______ (if applicable)
Vaccine Lot #:	Administering Pharmacist Signature:
Vaccine Expiry Date (MM/YYYY): _______/_______	Administering Pharmacist OCP #:
Administering Pharmacist Signature:	Date & Time of Follow-up with Patient/Agent:
Administering Pharmacist OCP #:	Notes:
Date & Time of Immunization:	

Agrilflu® and Fluad® are registered trademarks of Novartis Vaccines and Diagnostics Inc. and are distributed by Novartis Pharmaceuticals Canada
Vaxigrip® is a registered trademark of Sanofi Pasteur SA and is distributed by Sanofi Pasteur Ltd.
Fluviral® is a registered trademark of ID Biomedical Corporation of Quebec and is distributed by GlaxoSmithKline Inc.
EpiPen® & EpiPen® Jr are registered trademarks of Mylan Inc. licensed exclusively to its wholly-owned affiliate, Dey Pharma, L.P.; sub-licensee, Pfizer Canada Inc.