Rexall™ FluShot

Consent for Immunization in the province of British Columbia

By provincial legislation, Pharmacists cannot administer a flu shot to children under 5.

Client Information

Last Name:	First Name:	
Address:	City:	Postal Code:
Emergency Contact Name:	Emergency Telephone Number:	
Personal Health Number (PHN) :	Date of Birth (MM/DD/YYYY):	
Gender:	Pregnant: ☐ No ☐ Yes ☐ N/A	

COVID-19 Screening Questionnaire

	YES	NO
1. In the past 10 days have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath or difficulty breathing, sore throat, runny nose?		
2. Do you have any of the following: chills, painful swallowing, stuffy nose, headache, muscle or joint ache, feeling unwell, nausea, vomiting, diarrhea or unexplained loss of appetite, loss of sense of smell or taste, conjunctivitis?		
3. In the past 14 days, did you return from travel outside of Canada or were in close contact with someone confirmed as having COVID-19?		

Other Health Information

☐ My immune system is affected by a severe disease or medication. If checked, please specify: _____

☐ I have had a serious life-threatening allergic reaction. Please specify: _____

☐ I have received another vaccine in the last 4 weeks. Please specify: _____

Consent ☐ Client ☐ Parent ☐ Legal guardian ☐ Representative

I understand the information in the HealthLink BC File(s) for the vaccine listed below. I understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. I have been informed of any medical reason why the vaccine listed below should not be given to me/my child. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine listed below unless the consent is cancelled.

☐ I consent to receiving/for my child to receive, the vaccine listed below.

☐ I agree that I may be asked to wait in the clinic/pharmacy for 15-20 minutes after getting the injection and will seek medical attention if needed.

☐ I will report any adverse effects I experience to the immunizing pharmacist.

☐ I consent for the information collected on this form to be provided to my Family Physician (or Physician of my choice) and to the Health Authority for entry into my immunization record. I understand the information will be used and disclosed in accordance with the Freedom of Information and Protection of Privacy Act and that summary statistical information may be reported to the Ministry of Health.

Name (PRINT) _____ Phone _____

Signature (Legal guardian or Representative, if applicable) _____ Date signed (YYYY/MM/DD) _____

☐ Patient verbal consent provided.

FOR PHARMACIST USE ONLY

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

Pharmacy Information

Pharmacist signature: _____ License number: _____

Date of administration (YYYY/MM/DD): _____ Time of administration: _____

Client Response

Before: Normal Yes ☐ No ☐ _____

During: Normal Yes ☐ No ☐ _____

Faxed to Public Health Unit: Yes ☐ No ☐

Name of Public Health Unit & Fax #: _____

15-30 mins post-administration: Normal Yes ☐ No ☐ _____

Notes: _____

Faxed to Physician: Yes ☐ No ☐

Name of Physician & Fax #: _____

The "Vaccine Consent Form" has been updated to "Consent for Immunization" form, in collaboration with members of the BC Immunization Committee (BCIC), which includes representatives from BC Ministry of Health Services, BC Centre for Disease Control, Health Authorities, Society of General Practitioners of BC and BC Pharmacy Association.