

2026/2027 INFLUENZA VACCINE CONSENT FORM

1. PATIENT INFORMATION

Patient Full Name: _____	Birth Date (mm/dd/yyyy): _____
Address: _____	Emergency Contact Name: _____
Phone Number: _____	Emergency Contact Phone Number: _____
Health Card Number: _____	Physician / Nurse Practitioner: _____
Gender (optional): _____	Physician / NP Phone Number: _____

2. HEALTH INFORMATION AND SCREENING

As of today:	Yes	No
Do you have a fever, infection, cough, shortness of breath, chest pain or feel unwell	☐	☐
Have you ever had a flu shot before?	☐	☐
Have you received any vaccinations in the last 6 weeks?	☐	☐
Have you ever fainted or had a serious reaction to any previous injection or vaccine(s) including Guillain- Barre Syndrome?	☐	☐
Do you have any allergies? Please list: (foods, medications, latex, vaccine components)	☐	☐
Do you have any chronic health conditions or immunodeficiencies? Please list:	☐	☐
Are you currently on any medications or immunosuppressants? Please list:	☐	☐
Do you have an active neurological condition?	☐	☐
Are you pregnant or breastfeeding?	☐	☐
Have you received blood products (containing immunoglobulin) in the last 3 months?	☐	☐

3. PATIENT CONSENT

As of today:	Yes	No
I have read or had explained to me and understand the benefits, side effects and risks of receiving and risks of not receiving the influenza vaccine.	☐	☐
I have had the opportunity to ask questions and I have received satisfactory answers.	☐	☐
I agree to stay in the pharmacy for at least 15 minutes after receiving the influenza vaccine or as directed by the pharmacist/nurse.	☐	☐
I authorize my pharmacist/nurse to notify my physician/nurse practitioner and/or public health of the vaccine received, any adverse events experienced and/or to contact me with any follow-up if needed.	☐	☐

AND:

☐ I consent to receive the influenza vaccine today **OR** ☐ I consent on behalf of the patient to receive the influenza vaccine today

Print Name _____ Relationship (if applicable) _____

Date _____ Phone Number _____

Signature _____

OR ☐ Verbal consent provided by patient/agent (circle) Consent given to _____

4. VACCINE INFORMATION – PHARMACY USE ONLY:

Pharmacy Name _____		Pharmacy Phone Number _____	
Influenza Vaccine Dosage: ☐ 0.5mL ☐ Other ☐ Afluria ☐ Flud ☐ Flulaval ☐ FluMist ☐ FluCelvax ☐ Fluzone HD ☐ Fluzone ☐ Fluviral ☐ Other _____	Administration Site Administration Route ☐ IM ☐ Intranasal Immunization Date _____ Immunization Time _____ AM ☐ PM Pharmacist / Health Care Provider Name _____ License No. _____ Signature _____	Deltoid: ☐ R ☐ L ☐ Other Notes/Observations (15-30 minute wait)	
Lot No. _____ Expiry Date _____			
Communication to other Health Care Providers (physician, nurse practitioner, public health) via: ☐ Fax ☐ Electronic Provincial Registry			