

VACCINE RECIPIENT INFORMATION

Name (Last, First):	Birthdate:	Age:
Address:	SK Health Services Number:	
Phone:	Sex shown on health card: ☐ M ☐ F ☐ X ☐ Not on card	

EMERGENCY CONTACT Name: _____ Phone: _____

SCREENING

The following questions will help determine if a vaccine is right for you. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist may have some additional questions.

1. Do you **feel sick today**? ☐ Yes ☐ No
2. Do you have **severe allergies** to **medications, food, a vaccine component** or **latex**? If yes, describe: ☐ Yes ☐ No
3. Have you ever had a **serious reaction** after receiving a vaccination (including, but not limited to, anaphylaxis, Guillain-Barré syndrome [GBS], myocarditis/pericarditis, oculorespiratory syndrome [ORS])? If yes, describe: ☐ Yes ☐ No
4. Do you have any of the following **medical conditions**:
 - ☐ **Asthma**
 - ☐ **Autoimmune disorder** (e.g., Crohn's disease, lupus, multiple sclerosis, psoriasis, rheumatoid arthritis, type 1 diabetes)
 - ☐ **Bleeding problems** ☐ Yes ☐ No
 - ☐ **Lymphatic circulation impairment** (e.g., lymphedema, axillary lymph node removal [mastectomy, lumpectomy], amputation)
 - ☐ **Multisystem inflammatory syndrome (MIS)**
 - ☐ **Cancer, HIV infection, Transplant, Thymus disease, other immune system disorders**
5. Do you **take any of the following medications** (currently, recently):
 - ☐ **Blood thinners** (e.g., Arixtra®, Aspirin®, Eliquis®, Lixiana®, Pradaxa®, Xarelto®, heparin, warfarin)
 - ☐ **Medications that affect the immune system** such as prednisone, other steroids, anticancer medications, transplant medications, medication used to treat inflammatory conditions (e.g., rheumatoid arthritis, Crohn's disease, psoriasis). If unsure, ask your pharmacist. ☐ Yes ☐ No
 - ☐ In the last 14 days have you taken **antibiotics** or **valacyclovir, famciclovir, acyclovir, oseltamivir, zanamivir, or baloxavir** (medications used to treat or prevention infection)?
6. Are you **pregnant**, could you be pregnant or are you planning on becoming pregnant? ☐ Yes ☐ No
7. Are you **breastfeeding/chestfeeding**? ☐ Yes ☐ No
8. Have you **received any vaccinations in the past 4 weeks** or have any **scheduled vaccines in the upcoming 4 weeks**? ☐ Yes ☐ No

Also answer Questions 9 to 12 if you will be receiving a live vaccine (ask pharmacist if unsure)

9. Are you under **19 years old** and regularly take a **salicylate medication(s)** (e.g., Aspirin®, bismuth subsalicylate, mesalamine, olsalazine, sulfasalazine)? ☐ Yes ☐ No
10. Do you **require a TB skin test** within the next 4 weeks or have you ever had a **positive TB skin test**? ☐ Yes ☐ No
11. Do you have **close contact** with anyone with a **weakened immune system**? ☐ Yes ☐ No
12. In the past year, have you received a **transfusion of blood/ blood products, or immune globulin (Ig)**? ☐ Yes ☐ No

Vaccine Providers: see the accompanying [guide](#) for interpretation of responses

Answer Q1-8 for inactivated vaccines including influenza and COVID-19. Answer all questions for live vaccines.

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DECLARATION OF CONSENT:

- I have read or had explained to me information regarding the risks, benefits, and potential side effects associated with the vaccine(s) and risks of not vaccinating.
- I have had the opportunity to have my questions answered by the pharmacist and understand the information I have been given.
- I understand the need for observation by the vaccine provider for at least 15 minutes after my vaccination and that in the rare occurrence of anaphylaxis, emergency treatment will be provided.
- I understand health information may be shared with another health care provider as necessary for care.
- I am the lawful parent/guardian entitled to make health care decisions for my child/dependent.
- I consent to the vaccine provider administering the vaccine for myself or my child/dependent.
- If applicable, I designate _____ to accompany my child _____ for a vaccine(s).
Name of Adult

Signature of:

Printed Name (if signed by parent/guardian/proxy)

Date

☐ Vaccine Recipient ☐ Parent /Guardian ☐ Proxy

Assessing Pharmacist: _____

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☐ Discussed publicly funded options (if applicable)		☐ Provided immunization fact sheet(s)				
☐ Product monograph and applicable immunization guidelines reviewed		☐ Available and applicable patient records reviewed (e.g., medication profile, PIP, and the eHR)				
☐ Assessed/confirmed weight for epinephrine dosing if vaccine recipient < 30 kg or using ampoules and < 46 kg: _____ kg						
Vaccine: Name, Manufacturer, DIN*, LOT#	Dose	Site	Route	Dose #	Administered^ by (Name)	Date & Time of Administration
1. fluviral 0242068 lot 4dz77 exp 30/06/2027	0.5mls					
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						
2. spikevax 02557770lot d05836a exp 23/05/27	0.5 ml					
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						
(Use next page to document administration of more than 2 vaccines.)						
Adverse reaction: ☐ No ☐ Yes - Vaccine(s) implicated:						
Describe reaction:					☐ Details recorded in patient profile	
☐ Completed Adverse Event Following Immunization (AEFI) form (publicly funded) OR Canada Vigilance Program Side Effect Reporting form (non-publicly funded)					☐ N/A (does not meet criteria)	
☐ Provided record of immunization						
☐ Notified prescriber or patient's primary care practitioner (NOT for COVID-19 or publicly funded Influenza)			Name:		Fax:	

*Not required as per bylaws but good practice to record

^ Or supervised, if applicable

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Vaccine Recipient Name:

Birthdate:

For Pharmacy Use Only (continued)

Vaccine: Name, Manufacturer, DIN*, LOT#	Dose	Site	Route	Dose #	Administered^ by (Name)	Date & Time of Administration
3. flud 65+ 02362384 lot418636 exp 25/06/27	0.7ml					
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						
4.						
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						
5.						
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						
6.						
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						
7.						
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						
8.						
Manufacturer's expiry date (vaccine & diluent, if applicable):			Beyond-use date/time, if applicable (e.g., storage, post-puncture):			
☐ Age appropriate ☐ Minimum interval met (if applicable)						

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