Sunnybrook
HEALTH SCIENCES CENTRE

Ambulatory Patient Pharmacy
2075 Bayview Avenue, Rm M1-101
Toronto, ON Canada M4N 3M5
Tel: 416-480-4502 Fax: 416-480-4503

COVID & FLU VACCINES - SCREENING AND CONSENT FORM – 2023-2024

Section 1: Patient Information

*First Name (as on OHIP)	*Last Name (as on OHIP)	*Health Card No.:	☐ Male ☐ Female ☐ Prefer not to answer
*Date of Birth (M/D/Y):	Age:	Tel:	Email:
Name of Emergency Contact AND Relationship:		Emergency Contact's Phone Number:	

***If Staff at Sunnybrook:** (Your info will be relayed to Sunnybrook OHS for documentation – please let staff know if you would like to do this yourself)
Department: **Sunnybrook Contact #:** **Employee # (if available):**

Section 2: Screening Questionnaire

	Yes	No
Have you been sick in the past few days? Do you have symptoms of COVID-19 or have a fever today?		
Have you had a serious allergic reaction to a vaccine or medication given by injection (e.g. IV, IM) needing medical care?		
Have you ever felt faint or fainted after receiving a vaccine or medical procedure?		
Are you allergic to any medications including vaccines?		
Do you have any serious allergy to latex or natural rubber?		
Do you have bleeding problems or use blood thinners (e.g. warfarin, ASA, rivaroxaban, etc.)?		
Have you received any other vaccines within the past 4 weeks? If so, which one(s)?		
Section 2a: Complete this section if receiving Flu Vaccine	**Yes**	**No**
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? (Note: egg allergies without other contraindications may be vaccinated as per NACI guidelines)		
Have you had wheezing, chest tightness or difficulty breathing within 24 hours of getting a flu shot?		
Have you had Guillian-Barré Syndrome within 6 weeks of getting a flu shot?		
Do you have any new or changing neurological disorder?		
If patient is under 9 years: has the child had previous influenza vaccines?		
Section 2b: Complete this section if receiving COVID Vaccine (XBB1.5)	**Yes**	**No**
Have you been diagnosed with myocarditis or pericarditis following a previous dose of an mRNA COVID-19 vaccine (e.g. Comirnaty (Pfizer), Spikevax (Moderna))?		
Have you had a serious allergic reaction within 4 hours of a COVID vaccine in the past?		
Have you had a known, or suspected allergy, or a severe anaphylactic allergic reaction (e.g. difficulties breathing, itchy/swelling of mouth or throat, hives) to polyethylene glycol [PEG], polysorbate 80 or tromethamine?		
Do you have a weakened immune system or are you taking any medications that can weaken your immune system (e.g. high dose steroids, chemotherapy)? *If yes, are you receiving stem cell therapy, CAR-T therapy, chemotherapy, immune checkpoint inhibitors, monoclonal antibodies, or other targeted agents?*		
Has it been a minimum of 84 days since your last COVID-19 vaccine dose and/ or COVID-19 infection?		
How many doses of COVID vaccine have you received in the past?	**0**	**1** **2+**

Section 3: Vaccine Administration Consent

- I have had an opportunity to ask questions about the diseases and the vaccines, and to have them answered to my satisfaction.
- I understand that I may withdraw this consent at any time for myself or for an individual for whom I am a substitute decision maker.
- I consent to have the Health Care Professional (HCP) administer the flu and/or COVID-19 vaccine to the individual named above.
- I understand the risks, benefits, expected outcome and possible side effects of this vaccine and agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after receiving the vaccination(s).
- **I agree that the pharmacy may share my personal health information regarding this vaccination as required with public health officials and other healthcare providers, including on COVaxON.**

☐ **I am providing consent for myself** **OR** ☐ **I am providing consent for the patient identified above**	☐ I consent to the COVID vaccine being given to myself or to the person for whom I am authorized to give consent. ☐ I consent to the influenza vaccine for 2023-2024 being given to myself or to the person for whom I am authorized to give consent.

Patient/Agent Name (& Relationship to person receiving this vaccination):	**Patient/Agent Signature:**	**Date Signed (DD/MM/YYYY):**

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PHARMACIST DECLARATION: I confirm that the patient named in this documentation is capable of, and has provided consent to, receive this COVID-19 vaccine and/or flu vaccine indicated in this document, or that a parent/ guardian or other agent has provided consent on behalf of the patient. I confirm that this COVID-19 and/or flu vaccine should be given to the patient based on my assessment. I confirm that the patient/agent has provided informed consent.

Pharmacist Signature:	**OCP License (See Below)**	**Date:**

Section 4: Pharmacy Use Only

COVID Vaccine

SPIKEVAX XBB.1.5 Vaccine (Moderna)	Comirnaty XBB 1.5 Vaccine (Pfizer)
Dose: ***0.5mL***	Dose: ***0.3mL***
Route: IM	Route: IM
Vaccine Lot#: **020G23A**	Vaccine Lot#:
Vaccine Expiry: **Jul 29, 2024**	Vaccine Expiry:

Site of Administration:
☐ **Left Deltoid** ☐ **Right Deltoid**
☐ **Other: _____**

Date of Immunization:

Time of Immunization: **AM / PM**

Flu Vaccine

☐ FLULAVAL TETRA® (MDV)
DIN 0242**0783**
Eligibility: Age 2yo+

☐ FLUZONE QUAD® (MDV)
DIN 0243**2730**
Eligibility: Age 2yo+

☐ FLUZONE QUAD® (PFS)
DIN 0243**0643**
Eligibility: Age 2yo+

☐ FLUZONE HIGH-DOSE®
DIN 02500523
Eligibility: Age 65yo+ (senior)

☐ FLUAD Adj-TIV®
DIN 0244**5646**
Eligibility: Age 65yo+ (senior)

Dose: 0.5mL (0.7mL for Fluzone HD)

Route: IM

Vaccine Lot#: | Vaccine Expiry:

Site of Administration:
☐ **Left Deltoid** ☐ **Right Deltoid**
☐ **Other: _____**

Date of Immunization:

Time of Immunization: **AM / PM**

Administering Pharmacist Name and OCP#:

◯ Shaun Barry (604258) ◯ Annie Hui (612172) ◯ Karen Lam (605530) ◯ Lily Marandi (622705) ◯ Clara Yung (603540)
◯ Dennis Cazzin (200248) ◯ Ariel Kwan (619452) ◯ Richard Lee (607850) ◯ Phoebe Quek (55786) ◯ Samantha Quach (615255)
◯ Daniel Ngai (607816) ◯ Kim Truong (605031) ◯ Frayda Gorenstein (55093)

Administering Pharmacist Signature:

Adverse Event Following Immunization? ☐ **Yes** ☐ **No**

If yes, describe nature of reaction and action(s) taken after 15 minutes?

Complete Below If Immunization Not Given

Reason immunization not given:

☐ Immunization is contraindicated
☐ HCP recommends immunization but no client consent
☐ HCP decision to temporarily defer immunization
☐ Other:

FOR EPINEPHRINE EMERGENCY TREATMENT
Section 1: Personal Information

***Patient First & Last Name (as it appears on your Health Card):	***Patient Health Card No.:	***Date of Birth (DD/MM/YYYY):

Age:	☐ Male ☐ Female	Patient Telephone:	*If person being immunized is a child (please circle):* *Child weigh's <30 kg (66 lb) Yes | No* *Has child had previous influenza vaccines)? Yes | No*

Name of Emergency Contact AND Relationship:	Contact's Best Contact Phone Number:

***If Staff at Sunnybrook:** (Your information will be relayed to Occupational Health for documentation unless otherwise notified by yourself)

Department: **Contact #:** **Employee # (if available):**

EPINEPHRINE EMERGENCY TREATMENT

☐ EpiPen® DIN 00509558 *PIN 09857423*	☐ Allerject® 0.3 mg/0.3 mL DIN 02382059 *PIN 09857440*	☐ Emerade™ 0.5 mg/0.5 mL DIN 02458454 PIN 09858130
☐ EpiPen® Junior DIN 00578657 *PIN 09857424*	☐ Allerject® 0.15 mg/0.15 mL DIN 02382059 *PIN 09857439*	☐ Emerade™ 0.3 mg/0.3 mL DIN 02458446 ☐ *PIN 09858129*

Number of Doses Administered:

Date of Administration:	Time(s) of Administration: 1. 2. 3.
Administering Pharmacist: Name & OCP#:	Administering Pharmacist Signature:

Additional Notes (including other emergency measures taken or treatments administered):

Date & Time of Follow-up with Patient/Agent: