Influenza Immunization Record

Print Form | Clear Form

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Age (Years)

Personal Health Number	Address	City	Postal Code	Phone

Emergency Contact – Last Name	First Name	Emergency Phone Number

Please answer the following questions and mark "X" in the appropriate box	Yes	No	N/A
Do you have a respiratory or active infection, fever, sudden cough, difficulty breathing, other flu-like or COVID-19 symptoms? (refer to www.healthlinkbc.ca for symptoms and self-assessment).			
Have you travelled outside of Canada in the last 14 days and/or in close contact with someone who has travelled outside of Canada in the last 14 days?			
Have you or anyone in your household been in close contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19? Or are you waiting for COVID-19 test results?			
If you answered "Yes" to any of the above questions, please DO NOT attend our flu clinic at this time. Self-isolate and use the COVID-19 Self-Assessment Tool at www.healthlinkbc.ca to determine whether you need to test for COVID-19.			
Have you ever received a flu vaccination?			
Have a history of Guillain-Barre Syndrome (muscle weakness, difficulty walking steady, paralysis) within 6 weeks of a flu shot?			
Have you ever fainted during or after an injection?			
Do you have severe allergies to the following: eggs or egg products, gelatin, neomycin, gentamicin, formaldehyde, kanamycin, neomycin or latex?			
Are you <5 years of age? Children <5 years of age will be immunized by public health. Note: Children who are < 9 yrs. of age and have never received a dose of influenza vaccine require 2 doses with a minimum spacing of 4 weeks between doses. ☐ **First Dose** ☐ **Second Dose**			
Have you received any vaccinations in the last 4-6 weeks? Which ones?			
Are you on any steroids or immunosuppressive, anticancer, antiviral, or any medications that affect the immune system? Or you have cancer, leukemia, HIV, or any other immune system problems?			
During the past year, have you received a blood transfusion, or been given medication called immune (gamma) globulin or had radiation therapy?			
Patients who have Chronic Lung, Chronic Kidney, or Heart Disease, Diabetes, Smoke, or 65 years of age: Have you received pneumococcal vaccines such as **Prevnar-13** or **Pneumovax-23**?			
Female only: Are you pregnant or breastfeeding, or planning to get pregnant or breastfeed within the next month?			

I understand there may be some soreness, redness, and swelling at the injection site for a few days. Less common reactions include mild fever, chills, malaise, and/or muscle aches (flu-like symptoms) and may typically resolve within 2 to 3 days. As with any vaccine, hypersensitivity reaction is possible. This is rare, but may constitute itchiness, hives or swelling. Save-On-Foods Limited Partnership ("SOF") has provided me with information of other risks related to the vaccine. I request and authorize SOF, through its employees and contractors, to administer the vaccine by injection. I have read and understand the risks of the vaccination and I acknowledge that I have had an opportunity to ask questions which were answered to my satisfaction. In return for the vaccination,

I agree to release SOF (including its employees, directors, officers, and contractors) from any and all liability, claims, injury, damages, costs, expenses and compensation whatsoever, howsoever arising, from or in any way connected with the vaccination. I understand and agree to remain at the location for 15-30 minutes after the injection as directed by the pharmacist. In the event of an emergency, I authorize the pharmacist to administer epinephrine and/or apply necessary life-saving procedures as an interim measure until medical support personnel arrive. I have read and understand the above information.

Participant Name (Please Print)	**Participant or Parent/Guardian Signature**	**Date**

Immunizer's Name (Please Print)	**Immunizer Signature**	**Date**

OFFICE USE | ☐ INFORMED CONSENT		
☐ Agriflu® TIV (Seqirus) 0.5mL	Lot#	Exp.
☐ Afluria® QIV (Seqirus) 0.5mL	Lot#	Exp.
☐ FluLaval Tetra QIV (GSK) 0.5mL	Lot#	Exp.
☐ FluMist QIV LAIV (AZ) 0.2mL	Lot#	Exp.
☐ Fluviral® TIV (GSK) 0.5mL	Lot#	Exp.
☐ Fluzone® HD 60mcg (SP) 0.5mL	Lot#	Exp.
☐ Fluzone® QIV 15mcg (SP) 0.5mL	Lot#	Exp.
☐ Influvac® QIV (MYL) 0.5mL	Lot#	Exp.
☐ Other	Lot#	Exp.
☐ Other	Lot#	Exp.
Site: **Arm** ☐ Left ☐ Right	**Intranasal** ☐	

Rx Label