Influenza Immunization Record **Save-On-Foods #:** **Clinic Location** Reset Form

Last Name	First Name	Date of Birth (MM-DD-YYYY)	Age (yrs.)	Gender

Personal Health Number	Address	Phone (Home)

City	Province **ALBERTA**	Postal Code	Phone (Other)

Emergency Contact – Last Name	First Name	Emergency Contact Phone No

Please answer the following questions and check an "X" in the appropriate box	Yes	No	N/A
Is this your first flu shot?			
Do you have a respiratory infection, fever, sudden cough, difficulty breathing, other flu-like, or COVID-19 symptoms or risk of COVID-19 exposure? If yes, do not attend flu clinic; refer to your health authority for symptom check and assessment.			
Do you have a history of Guillain-Barre Syndrome (e.g. muscle weakness, difficulty walking steady, paralysis) within 6 weeks of a flu shot?			
Have you ever fainted during or after an injection?			
Have you received any vaccinations in the last 4-6 weeks? Which ones?			
Do you have severe allergies to latex, food, any medications, or components of a vaccine (e.g. eggs or egg products, gelatin, neomycin, gentamicin, formaldehyde, kanamycin, neomycin, polyethylene glycol, polysorbate)?			
Are you < 9 yrs. of age and have never received a dose of seasonal Influenza vaccine? **Note**: Children who are < 9 yrs. of age and have never received a dose of seasonal influenza vaccine require 2 doses with a minimum spacing of 4 weeks between doses. ☐ **First Dose** ☐ **Second Dose**			
Are you on any steroids or immunosuppressive, anticancer, antiviral, or any medications that affect the immune system?			
Do 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?			
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 2-3 days. As with any vaccine, hypersensitivity reaction is possible. This is rare, but may include itchiness, hives, and/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 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 First/Last Name (Please Print)	**Participant / Parent / Caregiver Signature**	**Date**

FOR OFFICE USE

☐ **PATIENT PROVIDED INFORMED CONSENT**				**Dose: ☐ Annual ☐ 1st dose ☐ 2nd dose*:**		
Priority List by Reason Code:			**PIN**	***(specific to children < 9 years after receiving first flu vaccination)**		
	50	Influenza Standard Dose	05666650	☐ Afluria® Tetra (Seqirus) 0.5mL IM	Lot #	Exp:
	50	Influenza High Dose	00000050	☐ FluLaval® Tetra (GSK) 0.5mL IM	Lot #	Exp:
				☐ Fluzone® (SF) 0.5mL IM	Lot #	Exp:
				☐ Fluzone® High Dose (SF) 0.7mL IM	Lot #	Exp:
				☐ Other:	Lot #	Exp:

Injection Date: **Inj. Time:**	**Site:** **Arm** ☐ Left ☐ Right ☐ **Intranasal**

Immunizer's First/Last Name (Print)	**Signature**	**Date**

Pharmacy Copy