Influenza Immunization Record

Print Form | Reset Form

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

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 your provincial health authority for symptom check and self-assessment).			
Have you been diagnosed with or tested positive for COVID-19 in the last 14 days?			
In the past 14 days, have you or anyone in your household been in close contact with someone who is being investigated or confirmed to have COVID-19?			
If you answered "Yes" to any of the above questions, please DO NOT attend our flu clinic at this time. Self-isolate and follow up with your local health authority for further instructions.			
Is this your first flu shot?			
Have you received a COVID-19 vaccine? If so, number of doses: ____ and type of vaccine(s): ____			
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 latex, food, medications, or components of a vaccine (e.g. eggs or egg products, gelatin, neomycin, gentamicin, formaldehyde, kanamycin, neomycin, polyethylene glycol, polysorbate)?			
Are you < 5 years of age? Children < 5 years of age will be immunized by public health. 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**			
Have you received any other vaccines in the past 8 weeks? If so, list: ____			
Are you on steroids, immunosuppressives, anticancer, antiviral, or any other medications that affect the immune system? Or do you have severe asthma or active wheezing, cancer, leukemia, 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?			
Individuals with chronic lung, disease chronic kidney disease, heart disease, diabetes, who smoke, or 65 years of age: Have you received the pneumococcal vaccine 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 First/Last Name (Please Print)	Participant / Parent / Guardian Signature	Date

Immunizer's Name (Please Print)	Immunizer Signature	License #

OFFICE USE | ☐ INFORMED CONSENT			OTHER VACCINES		
☐ Afluria® QIV (Seqirus) 0.5mL IM	Lot#	Exp	☐ Prevnar 13 (PFE) 0.5 mL IM	Lot#	Exp
☐ FluLaval Tetra QIV (GSK) 0.5mL IM	Lot#	Exp	☐ Pneumovax 23 (MRK) 0.5mL	Lot#	Exp
☐ FluMist QIV LAIV (AZ) 0.2mL Nasal	Lot#	Exp	☐ Shingrix®(GSK) 0.5mL IM	Lot#	Exp
☐ Fluzone® HD QIV 60mcg (SP) 0.7mL IM	Lot#	Exp	☐ Other	Lot#	Exp
☐ Fluzone® QIV 15mcg (SP) 0.5mL IM	Lot#	Exp	☐ Other	Lot#	Exp
☐ Influvac® QIV (MYL) 0.5mL IM	Lot#	Exp	☐ Other	Lot#	Exp
Site: Arm ☐ Left ☐ Right Intranasal ☐			**Site: Arm ☐ Left ☐ Right**		

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