Influenza/COVID-19 Immunization Record

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 vaccine assessment questions and mark "X" in the appropriate box	Yes	No	N/A
Do you have a respiratory or active infection, such as fever, sudden cough, difficulty breathing, or other COVID-19 symptoms?			
Have you been diagnosed with, tested positive, or been in contact with someone who has COVID-19 in the last 10 days?			
Is this your first flu shot?			
Have you received any other vaccines in the past 8 weeks? If so, list:			
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 a previous vaccine or the components (e.g., eggs or egg products, gelatin, neomycin, gentamicin, formaldehyde, kanamycin, neomycin, **tromethamine, polyethylene glycol, polysorbate-80**)?			
Are you < 4 years of age? Children < 4 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**			
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?			
Female only: Are you pregnant or breastfeeding, or planning to get pregnant or breastfeed within the next month?			
During the past year, have you received a blood transfusion, or been given medication called immune (gamma) globulin or had radiation therapy?			
Answer the following questions if you will be receiving a COVID-19 vaccine			
Is this your first COVID-19 shot? If no, # of doses: ____ and name of past COVID-19 vaccine(s): ____________________________			
Have you been previously infected with Covid-19? If so, how long ago? _________			
Do you have a history or been diagnosed with Multisystem Inflammatory Syndrome in Children (MIS-C) or Adults (MIS-A) within the last 3 months?			
Do you have a history of myocarditis / pericarditis (inflammation of the heart or lining of the outside of the heart) OR have suffered from myocarditis or pericarditis after a previous dose of a COVID-19 vaccine?			

☐ 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			☐ Dose 1 ☐ Dose 2 ☐ Dose 3 ☐ Booster Dose #:_______________		
Flu Vaccines	**Lot#**	**Expiry Date**	**COVID-19 / Other Vaccines**	**Lot#**	**Expiry Date**
☐ Afluria® QIV (SQ) 0.5mL IM			☐ Pfizer/BioNTech (mRNA) IM		
☐ FluLaval Tetra QIV (GSK) 0.5mL IM			☐ Moderna (mRNA) IM		
☐ Fluad® (SQ) 0.5mL IM			☐ Moderna Bivalent (mRNA) IM		
☐ Flucelvax (SQ) 0.5mL IM			☐ Novavax (protein subunit) IM		
☐ FluMist QIV LAIV (AZ) 0.2mL Nasal			☐ Prevnar 13 (PFE) 0.5 mL IM		
☐ Fluzone® High-Dose (SP) 0.7mL IM			☐ Prevnar 20 (PFE) 0.5 mL IM		
☐ Fluzone® QIV 15mcg (SP) 0.5mL IM			☐ Pneumovax 23 (MRK) 0.5mL		
☐ Influvac® QIV (MYL) 0.5mL IM			☐ Shingrix®(GSK) 0.5mL IM		
☐ Supemtek™ QIV (SP) 0.5mL IM					
Site: Arm ☐ Left ☐ Right Intranasal ☐			**Site: Arm ☐ Left ☐ Right**		

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