INJECTABLE INFLUENZA VACCINE
CONSENT FORM (WRITTEN)

1 CLIENT INFORMATION

Complete Sections 1, 2, and 3 (please print)

Last Name:	First Name:	Date of Birth (YYYY/MM/DD):
Address:		Telephone Number:
Emergency Contact and Relation:		Emergency Telephone Number:
Personal Health Number:	Sex: ☐ Female ☐ Male ☐ Transgender	Pregnancy Status: ☐ No ☐ Yes ☐ N/A

2 OTHER HEALTH INFORMATION

☐ My immune system is affected by a severe disease or medication. If checked, please specify: _____

☐ I have had a serious and/or life-threatening allergic reaction to a vaccine/food/drug. Please specify: _____

☐ I have a history of Guillain-Barré syndrome (GBS) within 8 weeks of receipt of a previous dose of influenza vaccine without another cause being identified.

☐ I have fainted during/after receiving a vaccine in the past.

☐ I am receiving a CTLA-4 inhibitor (e.g. ipilimumab) alone or in combination with other checkpoint inhibitors for the treatment of cancer. *

3 CONSENT

☐ Client ☐ Parent ☐ Legal guardian ☐ Representative

I understand the information in the HealthLink BC File(s) for the vaccine listed below. I understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. I have been informed of any medical reason why the vaccine listed below should not be given to me/my child. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine listed below unless the consent is cancelled.

☐ I consent to receiving/for my child to receive, the vaccine listed below.
☐ I will stay in the pharmacy for at least 15 minutes after the injection and seek medical attention if needed.
☐ I will report any adverse effects I experience to the immunizing pharmacist.
☐ I understand the information may be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act* and that summary statistical information may be reported to the Ministry of Health.

Name (PRINT) _____ Phone _____

Signature _____ Date signed (YYYY/MM/DD) _____

FOR PHARMACIST USE ONLY

4 VACCINE INFORMATION

Name of vaccine: _____ DIN: _____

Dose: _____ mL Site: LA / RA Route: IM

Lot #: _____

Expiry date (YYYY/MM/DD): _____

LA left arm; RA right arm; IM intramuscular

Pharmacy Label

5 PHARMACY INFORMATION

Pharmacist signature: _____ Licence number: _____

Date of administration (YYYY/MM/DD): _____ Time of administration: _____

6 CLIENT RESPONSE

Before: Normal Yes ☐ No ☐ _____ **15-30 mins post-administration:** Normal Yes ☐ No ☐ _____

During: Normal Yes ☐ No ☐ _____ **Other comments:** _____

*Inactivated influenza vaccine should be given 8 weeks before starting treatment or 8 weeks after the last CTLA-4 inhibitor dose. For more specific details refer to the BC Cancer Influenza vaccine recommendations.