CONSENT FOR IMMUNIZATION WITH FLUMIST® (VERBAL)

❶ 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

❷ OTHER HEALTH INFORMATION*

Do you have any of the following:	Yes	No
History of anaphylactic reaction to a previous dose of any type of influenza vaccine or to any component of FluMist®?		
Severe asthma or active wheezing (on high dose inhaled or oral steroids or medically attended wheezing in the 7 days prior to vaccination)?		
Immunocompromising conditions (*applies to both adults and children*)?		
History of Guillain-Barré syndrome (GBS) within 8 weeks of receipt of a previous dose of influenza vaccine without another cause being identified?		
For individuals aged 2-17 years: are you currently receiving aspirin-containing therapy?		
Have you received a CTLA-4 inhibitor (eg. ipilimumab) alone or in combination with other checkpoint inhibitors for the treatment of cancer?		
Are you a healthcare worker who work with immunocompromised individuals?		

***PHARMACIST: If patient answers "Yes" to any of these questions, FluMist® is contraindicated and should not be administered.**

❸ CONSENT ☐ Client ☐ Parent ☐ Legal guardian ☐ Representative

The patient was provided and understood the information from HealthLinkBC File(s) for the vaccine listed below. They understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. They have been informed of any medical reason why the vaccine listed below should not be given to them/their child, if any. They have had the opportunity to ask questions that were answered to their satisfaction. They gave their consent voluntarily and understand that this consent is valid for the vaccine listed below unless the consent is cancelled.

☐ They consent to receiving/their child to receive the vaccine listed below.
☐ They agree to stay in the pharmacy for at least 15 minutes after the injection and seek medical attention if needed.
☐ They agree to report any adverse effects they experience to the immunizing pharmacist.
☐ They consent for the information collected on this form to be provided to my Family Physician (or Physician of their choice) and to the Health Authority for entry into their immunization record. They understand the information will 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 of Person Providing Consent:	Telephone Number (if different from above):	
Pharmacy Staff (who obtained consent):	Date Consent Obtained (YYYY/MM/DD):	Time Consent Obtained:

FOR PHARMACIST USE ONLY

❹ VACCINE INFORMATION

Name of vaccine: _____ DIN: _____

Dose: _____ mL Site: LA / RA Route: IM / SC / ID / IN

Lot #: _____

Expiry date (YYYY/MM/DD): _____

LA left arm; RA right arm; IM intramuscular; SC subcutaneous; ID intradermal; IN intranasal.

Pharmacy Label

❺ PHARMACY INFORMATION

Pharmacist signature: _____ Licence number: _____

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

❻ CLIENT RESPONSE

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

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