PATIENT QUESTIONNAIRE *INFLUENZA VACCINE - INJECTION*

Walmart Pharmacy

PATIENT INFORMATION

Name:		**DOB:**		**Age:**	
Address:		**Weight:**		❒ M ❒ F	
		EMERGENCY CONTACT			
Phone:		**Name:**			
Health Card #:		**Phone:**			

SCREENING QUESTIONNAIRE

Your answers to these questions will help the pharmacist determine if there is any reason you should not receive the flu vaccine today. If you are a parent or a guardian providing consent for another child or person, please complete the form for the person being vaccinated. *If a question is not clear, please ask your pharmacist to explain it.*

ANSWER THE FOLLOWING QUESTIONS	YES	NO
Is this your **first time** receiving the flu vaccine?	❒	❒
Are you **sick today** (i.e. fever, breathing problems, active infection)?	❒	❒
Do you have any **allergies/restrictions**? *Check all that apply:* ❒ Chicken Protein ❒ Gentamicin ❒ Neomycin ❒ Formaldehyde ❒ Egg/Egg Protein ❒ Kanamycin ❒ Latex/Natural Rubber ❒ Thimerosal *Specify all other allergies:* _____	❒	❒
Have you had a severe, life-threatening **allergic reaction** to a flu vaccine **in the past**?	❒	❒
Have you had **wheezing, chest tightness or difficulty breathing** within 24 hours of getting a flu vaccine?	❒	❒
Have you had **Guillain-Barré Syndrome** (autoimmune disorder) within 6 weeks of getting a flu vaccine?	❒	❒
Do you have a **new or changing neurological disorder**?	❒	❒
Do you have a **bleeding disorder or use blood thinners** (i.e. warfarin, aspirin), or have you had a **recent bleed**?	❒	❒

PATIENT DECLARATION OF CONSENT

I, the patient/agent, have received sufficient information to make an informed decision about receiving the influenza vaccine. I have had the opportunity to ask questions and answers have been given to my satisfaction. I understand the risks of receiving the vaccine and agree to wait in the pharmacy for 15 minutes after receiving it (or any other time recommended by the pharmacist). Potential side effects include, but are not limited to, soreness/redness/swelling at the injection site, fever, headache, muscle aches and fatigue.

An extreme allergic reaction/anaphylaxis is rare, but possible, and can be life-threatening. Symptoms of anaphylaxis include, but are not limited to, hives, difficulty breathing and swelling of the tongue/throat/lips. In the event of a medical emergency following the vaccination, I agree to have the pharmacist take measures to treat the emergency. This may include calling 911, administering epinephrine, diphenhydramine and beta-agonists, and providing CPR.

I acknowledge that the pharmacist may provide information related to this vaccination to the appropriate agent, health care provider, regulatory body and/or emergency services to comply with mandatory reporting requirements and/or voluntary reporting for the purposes of vaccine improvement. I am aware that I may be contacted by such individual(s) regarding any adverse reaction related to the vaccination.

❒ **I confirm that I want to receive the seasonal influenza vaccine**

OR

❒ **I confirm that I want my child to receive the seasonal influenza vaccine**

Patient/Agent Name (& Relationship)	**Patient/Agent Signature**	**Date**

PHARMACIST DECLARATION *(Pharmacy Use Only)*

I confirm the patient/agent named on page 1 is capable of providing consent for the influenza vaccine and that the vaccine should be given to the patient.

Pharmacist Name (& License Number)	**Pharmacist Signature**	**Date**

VACCINE INFORMATION *(Pharmacy Use Only)*

❒ AFLURIA TETRA	15µg/0.5mL	VIA	SEQ	QIV	DIN 02473313
❒ AFLURIA TETRA	15µg/0.5mL	SYR	SEQ	QIV	DIN 02473283
❒ AGRIFLU	15µg/0.5mL	SYR	SEQ	TIV	DIN 02346850
❒ AGRIFLU	15µg/0.5mL	VIA	SEQ	TIV	DIN 02428881
❒ FLUAD	15µg/0.5mL	SYR	SEQ	TIV	DIN 02362384
❒ FLULAVAL TETRA	15µg/0.5mL	VIA	GSK	QIV	DIN 02420783
❒ FLULAVAL TETRA	15µg/0.5mL	SYR	GSK	QIV	DIN 02478978
❒ FLUVIRAL	15µg/0.5mL	VIA	GSK	TIV	DIN 02420686
❒ FLUZONE	15µg/0.5mL	SYR	SPL	QIV	DIN 02420643
❒ FLUZONE	15µg/0.5mL	VIA	SPL	QIV	DIN 02432730
❒ FLUZONE HD	60µg/0.5mL	SYR	SPL	TIV	DIN 02445646
❒ INFLUVAC TETRA	15µg/0.5mL	SYR	BGP	QIV	DIN 02484854

❒ **Other:**

Expiry:		**Lot #:**	
Dose:	0.5 mL	**Route:**	**IM**
Site of Administration:	❒ Left Deltoid ❒ Right Deltoid		

ADMINISTERING PHARMACIST

Name:			
License #:			
Date:		**Time:**	
Signature:			

MONITORING & NOTES *(Pharmacy Use*

Evidence of reaction after_____minutes?
❒ Yes ❒ No

If yes, provide details below:

Other Comments/Plans for Follow Up:

NOTIFICATION *(If Applicable)*

Date:		**Method:**	❒ Fax:
HCP Name:			❒ Other: