

## VACCINE RECIPIENT INFORMATION

Name: (Last, First)		Date of Birth:	Age:
Address:	Postal Code:	Health Services Number:	
Phone Number:		Sex shown on health card: <input type="radio"/> M <input type="radio"/> F <input type="radio"/> X <input type="radio"/> Not on card	

**EMERGENCY CONTACT** Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## SCREENING

The following questions will help determine if a vaccine is right for you. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist may have some additional questions.

1. Do you **feel sick today**?  Yes    No
2. Do you have **severe allergies to medications, food, a vaccine component or latex**? If yes, describe:  Yes    No
3. Have you ever had a **severe reaction after receiving a vaccination**? If yes, describe:  Yes    No
4. Do you have any of the following **medical conditions**:
  - Asthma**
  - Autoimmune disorder** (e.g., Crohn's disease, lupus, multiple sclerosis, psoriasis, rheumatoid arthritis, type 1 diabetes)
  - Bleeding problems**  Yes    No
  - Lymphatic circulation impairment** (e.g., lymphedema, axillary lymph node removal [mastectomy, lumpectomy], amputation)
  - Multisystem inflammatory syndrome in children (MIS-C)**
  - Cancer, HIV infection, Transplant, other immune system disorders**
5. Do you **take any of the following medications** (currently, recently):
  - Blood thinners** (e.g., aspirin, Eliquis®, Lixiana®, Pradaxa®, Xarelto®, heparin, warfarin)
  - Medications that affect the immune system** such as prednisone, other steroids, anticancer medications, transplant medications, medication used to treat inflammatory conditions (e.g., rheumatoid arthritis, Crohn's disease, psoriasis). If unsure, ask your pharmacist.  Yes    No
  - Antiviral medications or antibiotics** (medications used to treat infection)
6. Are you **pregnant**, could you be pregnant or are you planning on becoming pregnant?  Yes    No
7. Are you **breastfeeding/chestfeeding**?  Yes    No
8. Have you **received any vaccinations in the past 4 weeks** or have any **scheduled vaccines in the upcoming 4 weeks**?  Yes    No

### Also answer Questions 9 to 12 if you will be receiving a live vaccine (ask pharmacist if unsure)

9. Are you **under 19 years** old and regularly take a **salicylate medication(s)** (e.g., ASA/aspirin, bismuth subsalicylate, mesalamine, olsalazine, sulfasalazine)?  Yes    No
10. Do you **require a TB skin test** within the next 4 weeks or have you ever had a **positive TB skin test**?  Yes    No
11. Do you have **close contact** with anyone with a **weakened immune system**?  Yes    No
12. In the past year, have you received a **transfusion of blood/ blood products, or immune globulin (Ig)**?  Yes    No

### Vaccine Providers: see the accompanying [guide](#) for interpretation of responses

Answer Q1-8 for inactivated vaccines including influenza and COVID-19. Answer Q1-12 for live vaccines.

**DECLARATION OF CONSENT:**

- I have read or had explained to me information regarding the risks, benefits, and potential side effects associated with the vaccine(s) and risks of not vaccinating.
- I have had the opportunity to have my questions answered by the pharmacist and understand the information I have been given.
- I understand the need for observation by the vaccine provider for at least 15 minutes after my vaccination and that in the rare occurrence of anaphylaxis, emergency treatment will be provided.
- I understand health information may be shared with another healthcare provider as necessary for care.
- I am the lawful parent/guardian entitled to make healthcare decisions for my child/dependent.
- I consent to the vaccine provider administering the vaccine for myself or my child/dependent.
- If applicable, I designate \_\_\_\_\_ to accompany my child for a \_\_\_\_\_ vaccine(s).  
Name of Adult

\_\_\_\_\_  
**Signature of:**  Vaccine Recipient  Parent /Guardian  Proxy **Name** (if not signed by vaccine recipient) **Date**

**Assessing Pharmacist:** \_\_\_\_\_

<b>For Pharmacy Use Only</b>						
<input type="radio"/> Discussed publicly funded options (if applicable)			<input type="radio"/> Provided immunization fact sheet(s)			
<input type="radio"/> Product monograph and applicable immunization guidelines reviewed (e.g., for screening question support, contraindications, warnings/precautions, and administration instructions)			<input type="radio"/> Available and applicable patient records reviewed (e.g., medication profile, Pharmaceutical Information Program, and the electronic Health Record)			
Vaccine: Name, Manufacturer, DIN*, LOT#, Expiry Date	Dosage	Site	Route	Dose #	Administered by (Name)	Date & Time of Injection
1.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						
2.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						
3.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						
(Use next page to document administration of more than 3 vaccines.)						
<b>Adverse reaction:</b> <input type="radio"/> No <input type="radio"/> Yes - Vaccine(s) implicated:						
<b>Describe reaction:</b>						<input type="radio"/> Details recorded in patient profile
<input type="radio"/> Completed Adverse Event Following Immunization (AEFI) <a href="#">form</a> (publicly funded) OR Canada Vigilance Program Side Effect Reporting <a href="#">form</a> (non-publicly funded)						
<input type="radio"/> Provided record of immunization						
<input type="radio"/> Notified primary care practitioner <small>(NOT for COVID-19 or publicly funded Influenza)</small>			<b>Name:</b>		<b>Fax:</b>	

**\*Not required as per bylaws but good practice to record**

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*Financial contribution:*



**For Pharmacy Use Only (continued)**

Vaccine: Name, Manufacturer, DIN*, LOT#, Expiry Date	Dosage	Site	Route	Dose #	Administered by (Name)	Date & Time of Injection
4.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						
5.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						
6.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						
7.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						
8.						
<input type="radio"/> Age appropriate <input type="radio"/> Minimum interval met (if applicable)						