

Vaccine Screening and Consent Form

(All Vaccines)

VACCINE RECIPIENT INFORMATION

Name: (Last, First)

Date of Birth:

Age:

Address:

Health Services Number:

Phone Number:

Sex: Male Female Other

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, please describe: Yes No

3. Have you ever had a **serious reaction after receiving a vaccination**? If yes, please describe: Yes No

4. Do you have any of the following **medical conditions**:

- Bleeding problems**
- Asthma**
- Lymphatic circulation impairment** (e.g. lymphedema, axillary lymph node removal [mastectomy, lumpectomy], amputation) Yes No
- Autoimmune disorder?** (e.g.: Crohn's disease, lupus, multiple sclerosis, psoriasis, rheumatoid arthritis, type 1 diabetes)
- Cancer, HIV infection, Transplant, Other immune system disorders**

5. Do you **take any of the following medications** (currently, recently):

- Blood thinners** (e.g. aspirin, warfarin, Eliquis®, Lixiana®, Pradaxa®, Xarelto®)
- 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 **nursing/breastfeeding**? 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 & 10 if you will be receiving a COVID-19 vaccine

9. Have you had a **previous COVID-19 infection**? Yes No

a. If yes to Q9, were you treated with **convalescent plasma or monoclonal antibodies**? Don't know Yes No

10. Are you **receiving a 3rd or 4th COVID-19 vaccine dose for travel purposes**? If yes, recipients need to sign this [form](#). Yes No

Also answer Questions 11 to 13 if you will be receiving a live vaccine

11. Do you **require a TB skin test** within the next 4 weeks or have you ever had a **positive TB skin test**? Yes No

12. Do you have **close contact** with anyone with a **weakened immune system**? Yes No

13. In the past year, have you received a **transfusion of blood/ blood products, or immune globulin (Ig)**? Yes No

Inactivated vaccines including Influenza Vaccine: Q1-8; COVID-19 vaccine: Q1 -10; Live vaccines: Q1-8 and 11-13

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

DECLARATION OF CONSENT:

- I have read or had explained to me the vaccine information sheet regarding the risks, benefits and potential side effects associated with the vaccine(s).
- 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.
- I understand health information may be shared with another healthcare provider as necessary for care.
- I consent to the vaccine provider administering the vaccine for myself or my child /dependent.

Signature of: _____

Vaccine Recipient Parent /Guardian Proxy

Name (if not signed by vaccine recipient) _____

Date _____

Assessing Pharmacist: _____

For Pharmacy Use Only

Discussed publicly funded options (if applicable)

Vaccine: Name, Manufacturer, DIN*, LOT#, Expiry Date	Dosage	Site	Route	Dose #	Administered by (Name)	Date & Time of Injection
1.						

Age appropriate Minimum interval met (if applicable)

2.						
----	--	--	--	--	--	--

Age appropriate Minimum interval met (if applicable)

3.						
----	--	--	--	--	--	--

Age appropriate Minimum interval met (if applicable)

4.						
----	--	--	--	--	--	--

Age appropriate Minimum interval met (if applicable)

Adverse reaction: No Yes - Vaccine(s) implicated:
Describe reaction:

Completed Adverse Event Following Immunization (AEFI) [form](#)

Provided record of immunization

Notified primary care practitioner (NOT for COVID-19 or Influenza) Name: _____

Fax: _____

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

No part of this work may be reproduced, distributed, or transmitted in any form or by any means unless authorized by medSask. For copyright permission requests, please contact druginfo@usask.ca.