medSask
YOUR MEDICATION INFORMATION SERVICE

PHARMACY ASSOCIATION OF SASKATCHEWAN

Vaccine Screening Tool and Consent Form

Patient information			
Name: (Last, First)	**Date of birth (YYYY-MM-DD)**		
Address:			
Health Services Number:	**Gender: M/F/O**	**Weight:**	
Daytime Phone Number:	**Alternate Phone Number:**		
Emergency Contact Information **Name:**	**Phone Number:**		

Screening: The following questions will help determine if a vaccine is right for you today. A "yes" to any question does not necessarily mean you should not be vaccinated, but your pharmacist should be aware of it and may have some additional questions for you. **Do you (or your child / dependent):**		
1. Feel sick today?	¨ Yes	¨ No
2. Have allergies to medications, food, a vaccine component, or latex?	¨ Yes	¨ No
3. Have a history of serious reaction after receiving a vaccination?	¨ Yes	¨ No
4. Have any of the following medical conditions: ¨ bleeding problems ¨ asthma ¨ cancer, HIV/AIDS or other immune system disorders	¨ Yes	¨ No
5. Take any of the following medications (currently, recently): ¨ blood thinners (aspirin, warfarin, dabigatran, rivaroxaban, apixaban, edoxaban, etc.) ¨ drugs used to treat immune system disorders such as prednisone, other steroids, or anticancer drugs ¨ drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, other immune system conditions ¨ antiviral drugs	¨ Yes	¨ No
6. Require a TB skin test within next 4 weeks? Have a history of a positive TB skin test?	¨ Yes	¨ No
7. Have close contact with anyone with a severely weakened immune system?	¨ Yes	¨ No
8. For women: Are you pregnant or breastfeeding? Is there a chance you could become xxxx pregnant during the next month?	¨ Yes	¨ No
9. Are you planning to travel in the next 4 weeks?	¨ Yes	¨ No
10. Have a history of any vaccinations in the past 4 weeks?	¨ Yes	¨ No
11. During the past year, have a history of receiving a transfusion of blood or blood products, or immune (gamma) globulin?	¨ Yes	¨ No

Q1-5 Injectable inactivated influenza vaccine **Q1-11 Other vaccines**

Declaration of Consent:

I confirm that I have read or had explained to me the attached 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 am satisfied with and understand the information I have been given. I consent to pharmacist prescribing and/or administering vaccine(s) for myself or my child / dependent.

____ _____________________

Signature of: ¨ **Vaccine recipient** ¨ **Parent /guardian** **Date**

For Pharmacist Use Only						
Vaccine: Name, DIN, Lot #, Expiry Date	**Dose**	**Site**	**Route**	**Dose #**	**Pharmacist Signature**	**Date &Time of Injection (If applicable)**
1.						
2.						
3.						
4.						

Adverse reaction: ¨ **No** ¨ **Yes – describe reaction below.** ¨ **Completed Adverse Event following Injection (AEFI)** form

¨ **Notified primary care practitioner: Name**_________________________________ **Fax #:**_________________________________

¨ **Reported immunization to electronic provincial registry (if applicable)**

¨ **If vaccination series, appointment date for next injection:** ____

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