Vaccine Screening and Consent Form
(All Vaccines)

medSask
YOUR MEDICATION INFORMATION SERVICE

VACCINE RECIPIENT INFORMATION

Name: (Last, First) | Date of Birth: | Age:

Address: | Postal Code: | Health Services Number:

Phone Number: | Sex shown on health card: ○ M ○ F ○ X ○ 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, 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**: ○ Yes ○ No
   - ○ **Bleeding problems**
   - ○ **Asthma**
   - ○ **Lymphatic circulation impairment** (e.g. lymphedema, axillary lymph node removal [mastectomy, lumpectomy], amputation)
   - ○ **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): ○ Yes ○ No
   - ○ **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
   - ○ **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 to 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. Do you have a history of: ○ **Myocarditis or Pericarditis** ○ **Multisystem Inflammatory Syndrome in Children** (MIS-C) ○ 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

PLEASE SIGN ON REVERSE

Last updated 6 Mar 2022

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) 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 health care 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: **Name** (if not signed by vaccine recipient) **Date**

○ **Vaccine Recipient** ○ **Parent /Guardian** ○ **Proxy**

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**

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