

Vaccine Screening and Consent Form

(All Vaccines)

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**:

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

Yes No

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

Antiviral medications or antibiotics (medications used to treat infection)

Yes No

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 

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**

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.

Financial contribution from



Public Health
Agency of Canada

Agence de la santé
publique du Canada