

Vaccine Screening and Consent Form Updated 10 OCT 2025

VACCINE REC	IPIENT INFORMATION								
Name: (Last, First)		Birthdate:	Age:					
Address:	Posta	l Code:	SK Health Services Number:						
Phone Number:			Sex shown on health card: O M O F O X O Not	on card					
EMERGENCY CON	TACT 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?			O Yes	O No				
2. Do you have sev	O Yes	O No							
3. Have you ever had a severe reaction after receiving a vaccination (including, but not limited to, anaphylaxis, Guillain-Barré syndrome (GBS), myocarditis/pericarditis)? If yes, describe:									
O Asthma O Autoimmune type 1 diabe O Bleeding pro O Lymphatic o lumpectomy O Multisystem O Cancer, HIV	O Yes	O No							
5. Do you take any O Blood thinne O Medications medicat (e.g., rh	O Yes	O No							
6. Are you pregna	nt, could you be pregnant or are you p	olanning on becoming p	regnant?	O Yes	O No				
7. Are you breastf	eeding/chestfeeding?			O Yes	O No				
8. Have you receive	d any vaccinations in the past 4 weeks	or have any scheduled v	accines in the upcoming 4 weeks?	O Yes	O No				
Also ans	wer Questions 9 to 12 if you w	ill be receiving α liv	ve vaccine (ask pharmicist	if unsure)				
	9 years old and regularly take a salic esalamine, olsalazine, sulfasalazine)?		g., Aspirin®, bismuth	O Yes	O No				
10. Do you require	αTB skin test within the next 4 weeks	s or have you ever had o	positive TB skin test?	O Yes	O No				
11. Do you have close contact with anyone with a weakened immune system?					O No				
12. In the past year, have you received a transfusion of blood/ blood products, or immune globulin (Ig)?					O No				

Vaccine Providers: see the accompanying guide for interpretation of responses

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



Vaccine Recipient Name:		Birthdate:
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DECLARATION OF CONSENT:

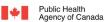
- · I have read or had explained to me information regarding the risks, benefits, and potential side effects associated with the vaccine(s) and risks of not vaccinating.
- I have had the opportunity to have my questions answered by the pharmacist and understand the information I have been given.
- I 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/quardian entitled to make healthcare decisions for my child/dependent.

		ering the vaccine for myself or my child/dependent. to accompany my child for a				vaccine(s).		
,, , , , , , , , , , , , , , , , , , , ,	Name of Adult	lt						
Signature of: O Vaccine Recipient O Parent/Guardia			ı me (if signe	d by parent/	/guardian/proxy)	Date		
Assessing Pharmacist:								
For Pharmacy Use Only			I					
O Discussed publicly funded option	O Discussed publicly funded options (if applicable)			O Provided immunization fact sheet(s)				
O Product monograph and applica reviewed (e.g., for screening questi warnings/precautions, and adn	on support, contro	aindications,	(e.g., m	nedication pr	licable patient record rofile, Pharmaceutico Health Record)	ds reviewed al Information Program,		
Vaccine: Name, Manufacturer, DIN*, LOT#, Expiry Date	Dosage	Site	Route	Dose #	Administered by (Name)	Date & Time of Injection		
1.								
O Age appropriate O Minimum	n interval met (if a	applicable)						
2.								
O Age appropriate O Minimum	n interval met (if a	applicable)	ı					
3.								
O Age appropriate O Minimum	n interval met (if a	applicable)						
(Use next page to document administration of	of more than 3 vaccin	es.)						
Adverse reaction: O No OYes -	Vaccine(s) impli	cated:						
Describe reaction:					O Details rec	orded in patient profile		
O Completed Adverse Event Follo Reporting <u>form</u> (non-publicly fu	-	ion (AEFI) <u>fo</u>	rm (publicly	funded) OR	Canada Vigilance P	rogram Side Effect		
O Provided record of immunization	on							
O Notified proscriber or nationt's	s primary care p	ractitioner	Nama			Eav:		

*Not required as per bylaws but good practice to record

(NOT for COVID-19 or publicly funded Influenza)

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Financial contribution:

Birthdate:

For Pharmacy Use Only (continued)						
Vaccine: Name, Manufacturer, DIN*, LOT#, Expiry Date	Dosage	Site	Route	Dose #	Administered by (Name)	Date & Time of Injection
4.						
O Age appropriate O Minimum int	erval met (if	applicable)				
5.						
O Age appropriate O Minimum int	erval met (if	applicable)				
6.						
O Age appropriate O Minimum int	erval met (if	applicable)				
7.						
O Age appropriate O Minimum interval met (if applicable)						
8.						
O Age appropriate O Minimum interval met (if applicable)						