Vaccine Screening and Consent Form

Updated 10 OCT 2025

VACCINE RECIPIENT INFORMATION

Name: (Last, First)		Birthdate:	Age:
Address:	Postal Code:	SK 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, describe:	○ Yes ○ 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:	○ Yes ○ No
4. Do you have any of the following **medical conditions**: ○ **Asthma** ○ **Autoimmune disorder** (e.g., Crohn's disease, lupus, multiple sclerosis, psoriasis, rheumatoid arthritis, type 1 diabetes) ○ **Bleeding problems** ○ **Lymphatic circulation impairment** (e.g., lymphedema, axillary lymph node removal [mastectomy, lumpectomy], amputation) ○ **Multisystem inflammatory syndrome (MIS)** ○ **Cancer, HIV infection, Transplant, Thymus disease, other immune system disorders**	○ Yes ○ No
5. Do you **take any of the following medications** (currently, recently): ○ **Blood thinners** (e.g., Arixtra®, Aspirin®, Eliquis®, Lixiana®, Pradaxa®, Xarelto®, heparin, warfarin) ○ **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 **breastfeeding/chestfeeding**?	○ 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 12 if you will be receiving a live vaccine (ask pharmicist if unsure)

9. Are you **under 19 years** old and regularly take a **salicylate medication(s)** (e.g., Aspirin®, bismuth subsalicylate, mesalamine, olsalazine, sulfasalazine)?	○ Yes ○ No
10. Do you **require a TB skin test** within the next 4 weeks or have you ever had a **positive TB skin test**?	○ Yes ○ No
11. Do you have **close contact** with anyone with a **weakened immune system**?	○ Yes ○ No
12. In the past year, have you received a **transfusion of blood/ blood products, or immune globulin (Ig)**?	○ Yes ○ 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.

PLEASE SIGN ON PAGE 2

Vaccine Recipient Name: | Birthdate:

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/guardian entitled to make healthcare 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: | **Printed Name** (if signed by parent/guardian/proxy) | **Date**

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

Assessing Pharmacist: _____

For Pharmacy Use Only

○ Discussed publicly funded options (if applicable)	○ Provided immunization fact sheet(s)
○ Product monograph and applicable immunization guidelines reviewed (e.g., for screening question support, contraindications, warnings/precautions, and administration instructions)	○ Available and applicable patient records reviewed (e.g., medication profile, Pharmaceutical Information Program, and the electronic Health Record)

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)						

(Use next page to document administration of more than 3 vaccines.)

Adverse reaction: ○ **No** ○ **Yes - Vaccine(s) implicated:**

Describe reaction: ○ **Details recorded in patient profile**

○ **Completed Adverse Event Following Immunization (AEFI) form (publicly funded) OR Canada Vigilance Program Side Effect Reporting form (non-publicly funded)**

○ **Provided record of immunization**

○ **Notified prescriber or patient's primary care practitioner** (NOT for COVID-19 or publicly funded Influenza) **Name:** **Fax:**

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

Financial contribution:
Public Health Agency of Canada | Agence de la santé publique du Canada

Vaccine Recipient Name:

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.						
○ Age appropriate ○ Minimum interval met (if applicable)						
5.						
○ Age appropriate ○ Minimum interval met (if applicable)						
6.						
○ Age appropriate ○ Minimum interval met (if applicable)						
7.						
○ Age appropriate ○ Minimum interval met (if applicable)						
8.						
○ Age appropriate ○ Minimum interval met (if applicable)						